

School of Occupational Therapy and Social Work

**A contemporary view of occupational therapy in acute hospitals in
metropolitan Western Australia**

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Master of Philosophy

of

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AUTHOR'S DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # OTSW-04-2011

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ABSTRACT

BACKGROUND

Occupational therapists working within general and tertiary hospitals face many practice challenges. Ongoing reforms within the Australian health context have seen a growing emphasis on ensuring system sustainability with the implementation of greater financial constraints with increased expectations around quality, accountability and safety. In Western Australia (WA) little has been evaluated regarding how these health system changes influence occupational therapy within an increasingly busy and restrictive acute hospital setting. To address this issue there were three principal objectives of the study. First, the study strives to provide a rich description of occupational therapy practice within the acute hospital setting. Second, it explores how external constraints within the acute hospital setting impact the practice processes of Western Australian occupational therapists. Last, the study seeks to contribute to the development of theoretical knowledge about occupational therapy practice within the acute hospital setting. Implications for future occupational therapy education and clinical practice are discussed.

METHODS

To achieve the study objectives, a two stage approach was used. In stage one a scoping review was completed to ascertain from the existing literature what is known about occupational therapy practice within acute hospitals. Knowledge gained from the scoping review informed the qualitative, second stage of the study. Following ethical approval, in-depth, semi-structured interviews, with a case study component were completed with 13 occupational therapists currently working on acute adult medical wards within metropolitan Perth, Western Australia. Occupational therapists working in mental health, paediatrics and rehabilitation were not included in the study. Data were collected on the nature of acute practice as described by the occupational therapists and analysed using a grounded theory approach. Themes were refined using a constant comparative method to identify the conceptual categories and core category that emerged from the data set.

RESULTS

In total 34 publications were included in the scoping review. Thematic analysis revealed four themes as they related to occupational therapy practice in acute hospital settings: 1) a comparison of the practice of novice and experienced occupational therapists in acute care; 2) occupational therapists and the discharge planning process; 3) role of occupation in the acute care setting; and 4) personal skills needed and organisational factors affecting acute care practice. The in-depth interviews with occupational therapists revealed five conceptual categories in relation to acute hospital practice. Two categories addressed the practice challenges experienced: (1) pragmatic organisational influences on client care; and (2) establishing a professional identity in the multi-disciplinary team. The practice challenges confirmed what is known in the current literature regarding the difficulties experienced by occupational therapists in the acute care setting. In addition, the study revealed three categories regarding how the occupational therapists were responding to these practice challenges. In the acute care setting occupational therapists focussed on (3) being the client advocate on their rapid hospital journey; (4) taking on the facilitator role to enable team action; and (5) engaging in a condensed form of clinical reasoning to meet workplace requirements. A core concept of modified practice emerged from the data analysis which reflected the instinctive, but often not recognised, changes occupational therapists were making to their daily practice in the acute care context. Acute occupational therapists are expanding into roles where a truncated form of their fundamental occupational therapy skills can exist within the restrictive parameters of this setting. By modifying their clinical reasoning processes and embracing a rapid form of the advocate and facilitator role, therapists ensure that occupational therapy remains relevant in the acute setting.

CONCLUSION

The study demonstrated that in response to workplace demands, occupational therapists working within the acute hospital are intuitively modifying their practice. Occupational therapy within the acute care setting currently centres on discharge

facilitation. Ongoing healthcare reforms have limited acute occupational therapists' ability to engage their clients in meaningful occupation-based treatment in every interaction. Subsequently, acute care occupational therapists are responding by placing increased importance on facilitating a strong sense of client-centeredness in this setting. By modifying their practice processes, occupational therapists are ensuring that fundamental occupational therapy skills continue to exist in acute care.

Within the healthcare system, ongoing reform will be sought to prepare acute hospitals for future demand. Occupational therapists are well placed to contribute more to client care in the acute hospital if innovations in service delivery are embraced. However, a number of personal and professional challenges to achieve this goal exist. Greater understanding by educators and clinical managers of how to respond to the socio-political factors occurring within the wider healthcare system is needed.

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LIST OF PUBLICATIONS

PUBLICATION ONE

The following manuscript was published December 2015 in the Australian Occupational Therapy Journal. This is a peer reviewed journal and evidence of this can be found in Appendix A.

Britton, L., Rosenwax, L., & McNamara, B. (2015). Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review. *Australian Occupational Therapy Journal*, 62(6), 370-377. doi: 10.1111/1440-1630.12227

PUBLICATION TWO

The following manuscript was accepted for publication in the Australian Occupational Therapy Journal 31st March 2016. This is a peer reviewed journal and evidence of this can be found in Appendix B.

Britton, L., Rosenwax, L., & McNamara, B. (2016). Occupational therapy in Australian acute hospitals: A modified practice. *Australian Occupational Therapy Journal*. doi: 10.1111/1440-1630.12298

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CONFERENCE PRESENTATIONS

Geddes, L., Rosenwax, L., & McNamara, B. (2012, October). A contemporary view of occupational therapy in acute hospital settings in metropolitan Western Australia. Paper presented at the OT Australia WA State Conference 2012, Perth, Western Australia.

Geddes, L., Rosenwax, L., & McNamara, B. (2013, July). What is contemporary acute care occupational therapy practice? Paper presented at the Occupational Therapy Australia 25th National Conference 2013 Adelaide, Australia.

STATEMENT OF CONTRIBUTION BY OTHERS

As co-authors of the following article:

Britton, L., Rosenwax, L., & McNamara, B. (2015). Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review. *Australian Occupational Therapy Journal*, 62(6), 370-377. doi: 10.1111/1440-1630.12227

We confirm that Lauren Britton has made the following contributions:

- Conceptualisation and design of research;
- Collection of data;
- Analysis and interpretation of results; and
- Writing paper and critical appraisal of content

Lorna Rosenwax

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Bev McNamara

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Date: 4/08/16

GLOSSARY OF TERMS

Activity Based Funding

Independently priced funding payments allocated to all Australian state and territory hospitals for services rendered under the direction of The National Partnership Agreement on Hospital and Health Workforce Reform (NPA) (Greco, 2010).

Acute care

Specialist care provided to critically unwell or injured persons. Treatment is provided in a time-sensitive and rapid approach with the purpose of improving health outcomes (Hirshon et al., 2013).

Four Hour rule (also known as Four Hour Rule Program)

Western Australian Department of Health initiative to manage bed block and patient flow from hospital emergency departments. Patient presentations to emergency departments are to be either discharged home or transferred to an inpatient ward within four hours (WA Department of Health, 2011).

Multi-disciplinary team

A multidisciplinary team (MDT) comprises members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality patient care and outcomes.

Symbolic interactism

All individuals are socially constructed and make sense of the world due to the process of social interaction (Mead 1962).

Tacit knowledge

The implicitly generated knowledge that develops after repeated exposure to the specific demands of an individual situation (Carrier, Levasseur, Bédard, & Desrosiers, 2010).

Tertiary hospital

Hospital that provides services requiring highly specialised skills, technology and support to all Western Australia. Typically a tertiary hospital may include centres of excellence, research and development; and will provide a leadership role for integrated clinical services. Interchangeably used with the term 'Teaching hospital' (WA Department of Health, 2014).

General hospital

A facility that provides services with a focus on the broader health needs of the community it serves, rather than a concentration on the purely clinical aspects of health care. A general hospital should provide for most of the health needs of its population. Interchangeably used with the term 'general hospital' (WA Department of Health, 2014)

ABBREVIATIONS AND ACRONYMS

ABF	Activity Based Funding
FHR	Four hour rule
OCC	Occupational Therapy Council (Australia and New Zealand) Ltd
OTAUS	Occupational Therapy Australia Ltd
OT	Occupational Therapy
WA	Western Australia
WFOT	World Federation of Occupational Therapists

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1. INTRODUCTION

1.1 OVERVIEW

Occupational therapy is a dynamic, client centred profession concerned with enabling people to participate in activities of everyday life through the therapeutic use of occupation (World Federation of Occupational Therapists, 2013).

Increasingly, factors outside the direct control of the profession are shaping the way occupational therapy is practised. The traditional notion of occupational therapy as solely rehabilitative is no longer applicable in all modern day healthcare settings.

Extensive changes to how healthcare is managed have occurred since the inception of the profession in the early 1900s (Gordon, 2008). Increasingly, attempts have been made to minimise the financial costs associated with growing healthcare usage (Frenk et al., 2010). Subsequently, a need to demonstrate economic accountability often overshadows how a client centred approach to practice can be achieved. For occupational therapy, this means daily practice has become a balancing act. Attempts to ensure practice is philosophically grounded are weighted against the need to demonstrate ongoing value to the health care system.

Occupational therapists, educators and managers alike are pushed to demonstrate 'best fit' in an evolving and rapidly expanding healthcare system (Freeman, McWilliam, MacKinnon, De Luca, & Rappolt, 2009).

On their own, fiscal changes will fail to future-proof the healthcare system for the demand that accompanies a growing population. Increasingly, innovation will be sought to develop new ways to manage and provide future healthcare (Day, 2015).

Technology and digital media are predicted to both change and challenge how health professions and consumers have historically interacted (Garrett, 2012).

Consumers are expected to demand a greater voice in any healthcare decision making. They will be more informed, and have access to more health information than ever before (Charlesworth, Jamieson, Butler, & Davey, 2015). The acute hospital, and more specifically the practice of occupational therapy in acute care, will not be immune to these anticipated changes to health provision.

Steady reductions in hospital length of stay and greater throughput of clients on acute wards have seen the scope of occupational therapy practice in acute care

decrease (Griffin, 1993). The push to reduce costs to the health care system means clients are now on the acute wards for the shortest time possible (Hargreaves, Grayson, & Titulaer, 2002). For occupational therapists, an identity of discharge facilitation has subsequently developed in this setting (Griffin & McConnell, 2001). Research to date on acute hospital practice is limited and focusses predominantly on the roles and tasks available to, and performed by, occupational therapists in this setting. While this research has been helpful in describing what occupational therapists do in the acute hospital, it does not provide insights into how occupational therapy can be practised in response to healthcare reforms. This thesis focuses on the acute hospital where occupational therapists are increasingly required to accommodate the effects of healthcare reform in their daily practice.

This thesis explores the issue of occupational therapy practice in the acute setting by addressing the following objectives:

1. To describe the scope of occupational therapy practice in acute care hospitals.
2. To identify the practice challenges experienced by occupational therapists in acute care hospitals.
3. To explore the practice processes, including clinical reasoning, used by occupational therapists within acute care hospitals.
4. To contribute to theoretical discussion about the nature of occupational therapy in acute care hospitals.
5. To discuss future implications for the education and clinical practice of occupational therapy.

1.1 A SYNOPSIS OF THE AUSTRALIAN ACUTE HEALTH CARE SYSTEM

To understand the context of this study, a brief description of the current health landscape and trends within acute hospitals is provided.

A review of historical and current literature regarding global healthcare identifies growing concern regarding the sustainability and accessibility of future health services (Charlesworth, et al., 2015; Day, 2015; Hawkes, 2013). Advances in medical management mean the health care of older Australians is becoming more complex, with many people living longer and with a greater number of co-morbidities (Hawkes, 2013). Within Western Australia, this aging population is placing growing demand on existing acute inpatient beds (Australian Institute of Health and Welfare, 2013b; Cunningham & Sammut, 2012; Hargreaves, et al., 2002). Regular access to the comprehensive care offered by acute hospitals has become necessary for the management of this patient demographic (Schofield & Earnest, 2006). Current health estimates indicate that 47-50% of all bed occupancy within Australian acute hospitals is by older Australians with this percentage expected to increase (L. C. Gray, Yeo, & Duckett, 2004). To minimise the costs associated with increased bed usage, recent changes to the provision and management of healthcare in Australia have occurred.

Federally, a need to streamline healthcare funding and enhance transparency within the healthcare system led to the formation of The National Partnership Agreement on Hospital and Health Workforce Reform in 2009 (Commonwealth of Australia, 2010). At a State level, further efficiency changes to the management of patient flow from Western Australian emergency departments was sought (WA Department of Health, 2014). The implementation of a Four Hour Rule Program ensured patients treated in an emergency department were either discharged or transferred to an inpatient ward in a timely manner (WA Department of Health, 2011). Additionally, increased accountability for healthcare spending was introduced through the Activity Based Funding model (Greco, 2010). Activity Based

Funding removed all state and territory lump sum health payments and replaced them with payment direct to hospitals based on services rendered (National Health and Hospitals Reform Commission, 2009).

However, for health professions such as occupational therapy, current fiscal accountability measures further constrict professional scope of practice in the acute hospital (Freeman, et al., 2009). Hospitals are currently incentivised to move patients through quickly to increase activity levels and funding. As throughput of clients increases, the time available to invest in client interactions and depth of occupational performance difficulties is impaired. Occupational therapists become increasingly dissatisfied with practice when their ability to demonstrate their professional skills is restricted by system limitations (Moore, Cruickshank, & Haas, 2006).

This thesis takes the central tenet of increased healthcare reform as a fundamental challenge for occupational therapists within acute hospitals. It raises questions about how best to remain true to fundamental principles of occupational therapy while fulfilling the requirements of an evolving health care system. A historical approach is presented in order to understand the evolution of occupational therapy within acute hospitals.

1.2 OCCUPATIONAL THERAPY IN ACUTE CARE

Within the acute hospital, occupational therapists are currently recognised for their role in facilitating client discharge and preventing hospital re-admissions (Blaga & Robertson, 2008; Roberts & Robinson, 2014). A progressive reduction in acute hospital length of stay has increasingly limited the breadth of occupational therapy practice in this setting (Griffin, 1993). An increased requirement to facilitate discharge means opportunities to invest in interventions is limited. Reinterpretation of the traditional assessment/ intervention/ discharge cycle into one of assessment/discharge only has been pronounced in acute care (Griffin, 1993; Griffin & McConnell, 2001).

International studies highlight the unique contribution occupational therapy makes on acute hospital wards with clients recovering from specific diagnostic conditions such as stroke and traumatic brain injury (Garraway, Akhtar, Prescott, & Hockey, 1980; Sale et al., 2014). However, occupational therapy practice within the general acute hospital is under-researched. Evidence of how compatible occupational therapy practice is with the acute hospital setting in the current climate of healthcare changes is lacking. Consequently, understanding of the practice processes specific to acute hospital occupational therapy is limited.

Occupational therapy is defined by the World Federation of Occupational Therapy as a 'client-centred health profession concerned with promoting health and wellbeing through occupation' (World Federation of Occupational Therapists, 2013). The primary objective of occupational therapy is to 'promote, maintain, or restore functional independence in daily living skills' (World Federation of Occupational Therapists, 2013). For occupational therapists working within the acute hospital setting the objectives and philosophy of practice remain the same. This thesis proposes that repeated exposure to the practice challenges in acute care have intuitively led occupational therapists to modify how they can successfully integrate occupational therapy principles into this setting.

Currently, 28.1% of occupational therapists practicing in Australia work within the hospital setting (Australian Institute of Health and Welfare, 2013a). However, within Australia, explicit education within occupational therapy curriculum on navigating the landscape of acute hospital practice appears sparse. Furthermore, no requirements exist for student fieldwork to include an acute hospital placement (Occupational Therapy Council (Australia & New Zealand) LTD., 2012). Despite this limited preparedness for practice, occupational therapy in acute hospitals is informed by the same fundamental body of knowledge as practice in other health and community settings. The conceptual models and frameworks developed and taught within occupational therapy help shape and guide client interventions in acute hospitals even without explicit instruction on its translation into this setting. For occupational therapy graduates who enter this practice setting, the ability to

successfully integrate occupational therapy knowledge in acute care is largely left to them to navigate.

Occupational therapists working in acute hospitals develop tacit knowledge in response to the specific requirements needed in this context, just as they do in all areas of practice (Carrier, Levasseur, Bédard, & Desrosiers, 2010). For occupational therapy within the acute hospital, the tacit knowledge that develops is inclusive of the specific practice processes, including clinical reasoning, that enable effective client driven outcomes in this setting. An ability to develop clinical reasoning and decision making skills is dependent on clearly defined assumptions about practice drawn from a conceptual basis (Elliott, Velde, & Wittman, 2002; Reed, 1998). Often difficult to articulate, the clinical reasoning of occupational therapists is seen as a subtle process that facilitates the client outcomes relative to the beliefs of the profession (C. Mattingly & M. Fleming, 1994; Mosey, 1996; Neistadt, 1998; L. Robertson, 2012; Schell & Cervero, 1993). Clinical reasoning within occupational therapy consists primarily of four main types: procedural, interactive, conditional and narrative (Fleming, 1994a, 1994b; Mattingly, 1994; C. Mattingly & M. H. Fleming, 1994). The transition and interplay of each type of reasoning enables a unique, client centred approach that is specific to the practice of occupational therapy. In order to understand the practice processes of occupational therapists within acute hospitals, critical analysis is necessary. Awareness of how occupational therapy decisions are made provides evidence of the modifications to practice that are occurring in light of ongoing healthcare reform.

In order to promote a clear future direction for occupational therapy in the acute hospital, it is firstly essential to understand current practice. Understanding how occupational therapists enable client-centred practice under current health care reforms is necessary to prepare graduates for effective work in this area. To date there have been few, if any, studies that examine the practice processes of occupational therapists in the acute hospital setting. By examining how decisions are made and what types of clinical reasoning are used in the context of a time

pressured health environment, future occupational therapists can be appropriately educated for this practice setting.

In summary, this thesis aims to contribute additional understanding of the acute hospital and the specific needs and requirements of occupational therapists working in this setting. Greater awareness of current practice is necessary to understand how best to prepare graduates for a health system where ongoing reforms are expected.

1.3 RATIONALE

First, limited evidence exists on the preparedness for acute hospital occupational therapy practice (M. Gray et al., 2012). Concerns regarding the transition of practice knowledge into clinical settings and supervision requirements have previously been highlighted (Craig, Robertson, & Milligan, 2004; Cusick, McIntosh, & Santiago, 2004; Elliott, et al., 2002). However, as governments continue to seek out ways to manage predicted healthcare expenditure and increasing consumer involvement in health care decision-making, occupational therapy graduates need to have the skills and knowledge of how best to develop a professional identity in a changing system. This study will contribute to the growing body of knowledge regarding how best to equip university graduates for all clinical practice areas, including acute hospitals, so as to ensure occupational therapy remains relevant in times of future health care change.

Secondly, the nature of occupational therapy practice in acute hospitals is largely seen within the profession as 'not true' occupational therapy practice (Baum & Law, 1997; Molineux, 2011). A lack of research and understanding of the true nature of acute practice has impeded the ability to develop a clear professional identity in this area of practice. For occupational therapists that work in this setting, an understanding of current practice is required so that they may be able to confidently articulate a clear identity and identify professional boundaries.

Thirdly, there are few Australian studies that explore occupational therapy practice in the acute care sector. Additional research will help add to the professional knowledge base of this area and provide evidence of practice outcomes. In the current climate of healthcare reform, understanding options for professional parameters in the acute hospital setting will aid occupational therapy accountability requirements.

1.4 STRUCTURE OF THESIS

This thesis is presented as an exegesis. Chapter one provides an introduction to the study, beginning with a synopsis of the Australian and Western Australia healthcare systems. An overview of occupational therapy practice in acute hospital settings is provided from a historical and current viewpoint. The profession's philosophy, graduate preparedness for practice and current challenges in the acute hospital setting are briefly outlined. Chapter two presents findings from the literature in the form of a scoping review. The question that guided the scoping review was: 'what is known from the existing literature about occupational therapy practice in acute physical hospital settings?' This publication entitled 'Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review' was published December 2015 in the peer reviewed *Australian Occupational Therapy Journal*. Chapter three provides an explanation of the research design to address the research objectives. This study was completed in two stages. The first stage involved the completion of a scoping review on all available evidence in regards to the research question. The findings of the scoping review informed the second stage of the study. Qualitative inquiry using a grounded theory approach was selected and in-depth interviews, with a case study component, were completed with occupational therapists practicing in acute hospital settings in Perth, Western Australia. Chapter four provides the key findings of this research study from within the Western Australian acute hospital context. The findings are presented in a publication entitled 'Occupational therapy in Australian acute hospitals; a modified practice' which was accepted for publication 31st March 2016 in the peer reviewed, *Australian Occupational Therapy Journal*. Chapter five presents the discussion of the

research study. The findings related to occupational therapy practice in acute hospital settings within a Western Australian context are discussed using current local and international published evidence. The discussion outlines the implications for occupational therapy practice from both an educational and a clinical perspective. Occupational therapists working in acute care need to work towards re-forming the profession in response to the changing health landscape which includes increased awareness of funding, openness to incorporating new technologies and approaches, and an active involvement of clients and their families in the health journey. Graduate preparedness for practice within current acute care hospitals is discussed. Recommendations for further research are also provided for the continued understanding of the needs and attributes of occupational therapists entering the acute practice context.

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2. PUBLICATION ONE: LITERATURE REVIEW

Review Article

Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review

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Background/Aim: Increased accountability and growing fiscal limitations in global health care continue to challenge how occupational therapy practices are undertaken. Little is known about how these changes affect current practice in acute hospital settings. This article reviews the relevant literature to further understanding of occupational therapy practice in acute physical hospital settings.

Method: A scoping review of five electronic databases was completed using the keywords Occupational therapy, acute hospital settings/acute physical hospital settings, acute care setting/acute care hospital setting, general medicine/general medical wards, occupational therapy service provision/teaching hospitals/tertiary care hospitals. Criteria were applied to determine suitability for inclusion and the articles were analysed to uncover key themes.

Results: In total 34 publications were included in the review. Analysis of the publications revealed four themes: (1) Comparisons between the practice of novice and experienced occupational therapists in acute care (2) Occupational therapists and the discharge planning process (3) Role of occupation in the acute care setting and (4) Personal skills needed and organisation factors affecting acute care practice.

Conclusion: The current literature has highlighted the challenges occupational therapists face in practicing within an acute setting. Findings from this review enhance understanding of how occupational therapy department managers and educators can best support staff that practise in acute hospital settings.

KEY WORDS occupational therapy research, review, service evaluation.

Introduction

Acute hospital settings can be fast paced, dynamic and stressful environments for health professionals. They are places of immense pressure, where the immediate health needs of unwell patients are met and managed. In these environments patients are treated and discharged in a matter of hours, with the ultimate aim being the facilitation of quick and efficient patient management within the health-care system.

Substantial numbers of occupational therapists work in the acute hospital setting. According to the latest allied health workforce figures, 28.1% of the Australian occupational therapy workforce is employed in this area of practice (Australian Institute of Health and Welfare, 2013). For occupational therapists, acute care settings are where many graduates aspire to commence their careers (Cusick, McIntosh & Santiago, 2004). A large peer support network and options for future learning through clinical rotations, continue to promote acute care settings as desirable places to work (Blaga & Robertson, 2008; Cusick *et al.*; Fortune, 2000).

With the ever-changing innovations in modern health care, occupational therapists are increasingly required to adapt their practice to new and often complex settings. An increased emphasis on accountability in health care and the development of new government policies means that the movement of patients within the health-care system has never been faster (Freeman, McWilliam, MacKinnon, De Luca & Rappolt, 2009).

Acute hospitals pose significant challenges for occupational therapists as they struggle to deal with the environmental and financial limitations that exist within this workplace (Shiri, 2006). Occupational therapy managers, now more than ever, struggle to deal with the decreased length of time patients spend in hospitals and the economically driven state of the health-care system (Hobbs, Boysen, McGarry, Thompson & Nordrum,

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2010). This results in constraints on the nature of the occupational therapy services that can be adequately provided in the time frame permitted (Griffin & McConnell, 2001).

For occupational therapists who practise in acute physical-care settings, daily work can bring increased pressures to perform in a manner congruent with a reductionist medical model rather than practice that aims to enable clients in meaningful engagement in their chosen occupations (Fortune, 2000). As a result the real role and purpose of occupational therapy can easily get lost in acute settings, as the 'orientation, purpose and language of the hospital is incommensurate with the principles of enhancing occupational engagement' (Wilding & Whiteford, 2008).

To date, no reviews exist that explore how occupational therapists practice in acute physical hospital settings. To address this gap we gathered, reviewed and evaluated the evidence available on the nature of occupational therapy practice in this hospital setting. This review is written principally for an Australian health context. Due to the limited evidence available on the Australian acute occupational therapy sector, international literature has been drawn upon due to the similarities that exist between Australian and other Western health-care settings.

Method

A scoping review is a 'form of knowledge synthesis that addresses an explanatory research question aimed at mapping key concepts, types of evidence and gaps in research related to a defined field' (Colquhoun *et al.*, 2014). This scoping review uses the framework recommended by Arksey and O'Malley (2005) to map the extent, range and nature of information in this research field (p. 6) using the following sections.

Identifying the research question

The research question that guided this scoping review was: what is known from the existing literature about occupational therapy practice in acute physical hospital settings?

Identifying relevant studies and study selection

Electronic searches were carried out in September 2014 for studies published from 1991 to 2013 using a combination of key words and MeSH terms.

- Occupational Therapy AND acute hospital settings OR acute physical hospital settings
- Occupational Therapy AND acute care setting OR acute care hospital setting
- Occupational Therapy AND general medicine OR general medical wards
- Occupational Therapy service provision AND teaching hospitals OR tertiary care hospitals.

Five databases were searched in addition to searches within grey literature on Google and Google Scholar: MEDLINE, Cumulative Index to Nursing & Allied Health (CINAHL), MEDNAR, SCOPUS and OT Seeker.

Selecting inclusion and exclusion criteria

The inclusion criteria were refined in consideration with the research question:

Papers about, or relevant to, occupational therapy practice in the acute physical hospital setting.

AND EITHER

- Contained evidence/perceptions of occupational therapy practice OR general hospital care OR emergency care service provision.

OR

- Were briefing papers, position papers, commentaries, editorials or conference keynotes on the topic of the occupational therapy role in acute care OR acute hospitals.

Papers were excluded that were:

- About acute hospital management of mental health or paediatric conditions
- About management of individual physical conditions including use of modalities and/or assessment tools by occupational therapists (i.e. mallet injury, stroke assessment)
- About care provided on long stay, care awaiting placement or acute rehabilitation wards
- About community and outpatient rehabilitation service provision
- Not in English.

Hand searching

Seminal articles were also collected from relevant citations identified on websites and reference lists. The articles were then applied to the inclusion/exclusion criteria to determine suitability for inclusion in this scoping review. Previous authors published in the field of acute occupational therapy were also approached to gain theses/publications that would meet the inclusion criteria and provide additional insight.

Charting the data

A data charting form was developed to record the following information of each study: author, year of publication, source of literature (journal article, editorial, etc.), research question or purpose of the study, practice setting, methodology and results. No articles/published works were critically appraised as this is not a requirement of the scoping review methodology (Arksey & O'Malley, 2005). Rather this scoping review aimed to examine the breadth of literature available on the research topic.

Results

Searches using the key words and MeSH terms identified 10,757 publications. The titles of these publications

were reviewed and 1377 were identified as potentially relevant to this review. The abstracts of these records were then reviewed by the first author and 99 were deemed to have met the inclusion criteria. Seventy one publications were excluded as duplicates reducing the total number to 28. A further six publications were identified from hand searching and selected for inclusion bringing the total number of included publications to 34.

A numerical and thematic analysis (Arksey & O'Malley, 2005) formed the analytical framework in which the narrative data were combined and examined. The papers were reviewed with publication dates 1993–2014; one publication (1993, 1994, 1998, 2002, 2006, 2007, 2009, 2014); two publications (2001, 2003, 2005, 2013); three publications (2004, 2011, 2012); four publications (2010); and five publications (2008).

The United Kingdom (UK), Australia and the United States produced the most publications (eleven, seven and seven respectively). New Zealand produced six publications and Hong Kong, Sweden and Canada one each. Twelve publications did not use a research methodology, 10 studies used a qualitative methodology, eight studies used a quantitative approach and four studies used a mixed methods approach.

Twenty-three journal articles were retrieved in addition to one book, one book review, five letters to/from journal editors, one briefing paper, two case reports and one PhD thesis.

Scopus database yielded the majority of publications retrieved in this search.

Thematic analysis

Analysis and charting of the publications retrieved for this scoping review identified four major themes discussed below.

(1) Comparing the practice of novice and experienced occupational therapists in acute care

Discussions regarding the practice of novice versus experienced therapists were explored by multiple authors across many of the different publication types (Crennan & MacRae, 2010; Cusick *et al.*, 2004; Griffin & McConnell, 2001; Holm, 2012). Some authors discussed the importance of novice therapists receiving regular support and supervision when working in the acute physical setting (Cusick *et al.*; Griffin & McConnell). This was linked to the challenging nature of the acute practice setting and the increased level of concerns younger therapists felt in practising in this setting as opposed to more experienced therapists (Crennan & MacRae; Cusick *et al.*; Griffin & McConnell). Clinical support for novice therapists was found to be essential in assisting skill development in this area. Variations in skill level of therapists lead to differences in clinical reasoning between novice and experienced clinicians in this setting; more experienced therapists tended to be

more comprehensive and objective in their assessments with clients as opposed to their novice counterparts (Crennan & MacRae).

Craig, Robertson and Milligan (2004) and Cusick *et al.* (2004) noted the importance of quality supervision as being essential for the retention of new graduate members of the occupational therapy department. Supervision allowed for opportunity to develop a better understanding of their role in the acute setting and the practical skills required for work (Cusick *et al.*). Role incompatibility was identified as being of concern to novice therapists in the acute setting (Crennan & MacRae, 2010; Cusick *et al.*; Griffin & McConnell, 2001; Wilding & Whiteford, 2008). The challenging nature of the acute practice setting characterised by short bed stays meant that novice therapists benefit from supervision from more experienced therapists who have more realistic expectations of what could be achieved in this setting (Griffin & McConnell). For occupational therapists to effectively use occupational therapy language and theory in the acute settings, additional supervision and closer interactions with other occupational therapists positively decreased the ambiguity and role incompatibility in this setting (Wilding & Whiteford, 2008).

Crennan and MacRae (2010) found discrepancies in how therapists perceived they could be more client centred in the acute setting. Novice therapists identified greater difficulty with enabling client-centred practice when facilitating complex discharges. Experienced occupational therapists, however, demonstrated greater clinical skills and client centeredness by seeking out relevant additional information to develop a more fluid framework in which to identify discharge options. More advanced clinical skills allowed therapists to anticipate safety issues earlier in the discharge process, increasing the likelihood of a safe facilitated discharge being enabled (Holm, 2012).

(2) Occupational therapists and the discharge planning process

The role of the occupational therapist in the discharge planning process was addressed in 32 of the 34 publications included in this review.

Authors such as Griffin (1993), Griffin and McConnell (2001) and Blaga and Robertson (2008) identified that the nature of acute occupational therapy practice in Australia and New Zealand is in part largely characterised by an ability to coordinate a safe, efficient and timely discharge. This was confirmed as being similar practice to the USA where therapists reported the need to facilitate effective discharges as an essential aspect of service provision (Holm, 2012; Roberts & Robinson, 2014). Effective, timely discharge was linked with a cost minimisation model as medical care in the USA is among the most expensive in the developed world (Crennan & MacRae, 2010; Holm). The role of assessing

and developing clear discharge goals for clients has become more fully endorsed within acute settings due to greater fiscal pressures within the health-care system (Griffin & McConnell; Holm; Sutton, 1998).

Publications addressing the occupational therapists role in the discharge process noticeably progress from the year 2000 onwards, where a growing emphasis on reducing length of stay and subsequently minimising costs to the health-care system is noted (Blaga & Robertson, 2008; Carlill, Gash & Hawkins, 2002; Craig *et al.*, 2004; Crennan & MacRae, 2010; Griffin & McConnell, 2001; Holm, 2012; Li-Tsang, 2003; Mearns, Millar, Murray & Fraser, 2008; Roberts & Robinson, 2014; L. Robertson & Blaga, 2013; Welch & Forster, 2003; Welch & Lowes, 2005).

The role of occupational therapy in the discharge process was positively viewed in assisting unnecessary hospital admissions and reducing costs to the system (Carlill *et al.*, 2002; Roberts & Robinson, 2014). An opinion piece by Li-Tsang (2003) details an academic exchange to the UK where the economic benefits of having occupational therapists facilitate discharge within the accident and emergency department were observed. The UK system was identified as a potential model to emulate within the Hong Kong hospital system where fiscal changes are negating a need to change service delivery (Li-Tsang). Sutton (1998) has previously shown in the Australian context that the role of the occupational therapist in an acute medical admissions unit was highly valued by the team in reducing client length of stay. She noted that occupational therapists in this setting were best placed to facilitate a quick discharge as they could access the necessary equipment and community follow up to ensure its success.

Three articles detailing the nature of practice in acute care identified that therapists felt their practices were predominantly defined by their ability to provide a safe and timely discharge home for patients (Blaga & Robertson, 2008; Craig *et al.*, 2004; Griffin & McConnell, 2001). To facilitate this, therapists often completed or referred for a home assessment to identify risks, observe client function and make safety recommendations (Atwal, McIntyre & Wiggett, 2012; Crennan & MacRae, 2010). Concepts of risk and acceptable levels of discharge risk were researched by Atwal *et al.*; Atwal, Wiggett & McIntyre, (2011). They found that perceptions of risk associated with discharge played an important part in the decision-making process for acute occupational therapists. High levels of perceived risks with regard to either safety to self or others were found to negatively affect clients' ability to be discharged to their pre-admission environment (Atwal *et al.*).

The timeliness of home assessments in the discharge process was raised as a concern by Robertson and Finlay (2007). Therapists reported feeling under pressure to complete home assessments urgently to continue the rapid throughput of clients. The pressure for rapid

discharge led to home assessments not always being completed at the right time or for the right reason (Welch & Lowes, 2005). Interdisciplinary team members were noted to request home assessments from the occupational therapist as a matter of course within the ward discharge process. This was often without consideration as to whether or not it was the most appropriate intervention and had the potential to lead to tension within the teams discharge facilitation (Welch & Lowes).

(3) Role of occupation in the acute care setting

Simmons Carlsson (2010) and Wilding and Whiteford (2008) spoke of the need for a transformational journey in acute practice to reconnect with the occupational foundations of occupational therapy. Wilding and Whiteford and Wilding (2008) highlighted the difficulty therapists in acute settings have with using words such as 'occupation' in daily practice, preferring instead to use terms such as 'function' to reduce perceived ambiguity by the broader multi-disciplinary team. Three publications spoke of empowering change in the occupational therapists approach in acute care (Simmons Carlsson; Wilding; Wilding & Whiteford). The importance of therapists completing a reflective process on their practice was identified as important to promote feelings of self-worth in this setting (Simmons Carlsson; Welch & Forster, 2003; Wilding).

Misunderstanding the nature of the therapists' role and value of occupational therapy in the acute setting was identified by a number of authors (Craig *et al.*, 2004; Griffin, 1993; Wilding, 2008). Therapists identified feelings of disconnect with the underlying philosophy of the profession when they were not able to 'do more' for their clients (Griffin & McConnell, 2001; Wilding & Whiteford, 2008). Concerns regarding an inability to fully meet professional and personal expectations in this setting were particularly noted by younger therapists (Griffin & McConnell; Robertson & Blaga, 2013). A cycle of assessment and discharge (Griffin) often left little time for other areas of occupational performance to be assessed and treated. Occupational therapy models of practice and theoretical frameworks were not identified by therapists as always essential to guide practice in the acute setting (Craig *et al.*; Griffin & McConnell). Craig *et al.* found that in New Zealand acute practice, therapists identified using a compensatory model with clients 75 per cent and the biomechanical model 63 per cent of the time. Occupational therapy models such as Model of Human Occupation (MOHO) and Canadian Model of Occupational Performance (CMOP) were identified as being used by only 33 per cent and 13 per cent of participants respectively to guide their acute practice. In 2008, Blaga & Robertson identified that in a similar acute context, 51.4 per cent of therapists identified using the CMOP as their theoretical framework as compared to only 38.5 per cent who used the biomechanical approach with clients. Maclean, Carin-Levy, Hunter,

Malcolmson and Locke (2012) expanded on previous research looking at the use of occupational therapy models by reporting on the use/applicability of a Person-Environment-Occupation (PEO) model in the acute setting.

Maclean *et al.* (2012) identified that unlike other occupational therapy models, the PEO offers shorter, more concise language which would be beneficial when explaining clinical decisions to other team members. Therapists in this research also identified the PEO framework was a more comfortable match to the acute care framework where rapid decision making and discharges are the priority. The model allowed therapists to better conceptualise their practice in this setting and articulate decisions to their teams.

Publications by Lu (2012), Smith-Gabai (2011) and Crennan and MacRae (2010) discussed opportunities and challenges presented to therapists in acute care for enabling client-centred practice. Lu reviewed the text *Occupational Therapy in Acute Care* (Smith-Gabai) in which it was proposed that the medical model can indeed be congruent with occupational therapy philosophy. The challenging nature of this setting still provided therapists with unique opportunities to be both occupation based and client centred (Lu; Smith-Gabai). Although Crennan and MacRae identified differences between how novice and experienced therapists reported the client-centred nature of their practice, it was felt that opportunities to maintain a client-centred approach could be found in this setting. These results were also confirmed by research completed by Holm (2012), where experienced therapists identified that by prioritising client-centred collaborations, a client-centred framework for the discharge planning process was enabled.

(4) Personal skills needed and organisation factors affecting acute care practice

A number of personal skills and factors affecting occupational therapy practice in acute care were identified from the literature. Time management was rated the most important personal skill required for practice in a number of studies (Craig *et al.*, 2004; Griffin & McConnell, 2001; Robertson & Blaga, 2013). Successful time management was positively associated with the ability to successfully manage the demands of a large and fluctuating caseload (Griffin & McConnell). Effective time management skills were congruent with having strong clinical reasoning and decision-making skills (Blaga & Robertson, 2008); a requirement when considering the risks associated with facilitating rapid and timely ward discharges. Having access to adequate supervision with a senior occupational therapist was strongly valued by novice therapists and was ranked as a highly valued resource in numerous studies (Blaga & Robertson; Craig *et al.*; Cusick *et al.*; Griffin, 1993; Griffin & McConnell; Simmons Carlsson, 2010). Supervision was positively

associated with the ability to retain new graduate staff in this setting as it provided them opportunities to develop strong clinical skills (Cusick *et al.*, 2004).

Relationships with multidisciplinary colleagues were identified as both an extremely valuable resource and a source of stress and frustration to therapists (Robertson & Finlay, 2007). Support from members of the wider multi-disciplinary team, was seen as a positive factor linked to increased understanding of the occupational therapy role in acute care (Craig *et al.*, 2004; Wilding, 2008). Teams with clear lines of communication provided therapists with greater clinical confidence when weighing up the risk associated with facilitating discharge (Atwal *et al.*, 2011). Teams with poorer communication could lead to therapists feeling undervalued in the acute setting and their role/purpose misunderstood (Wilding; Wilding & Whiteford, 2008). Occupational therapists valued clear communication lines with clients and often facilitated this communication with families and other members of the health-care team (Craig *et al.*). Access to written information was also positively identified as a resource necessary for effective communication to clients (Blaga & Robertson, 2008; Crennan & MacRae, 2010; Griffin & McConnell, 2001; Robertson & Blaga, 2013).

Many studies identified that facilitating a safe discharge using adaptive equipment and community services was now a fundamental requirement of acute care practice (Craig *et al.*, 2004; Griffin & McConnell, 2001; Sutton, 1998; Welch & Forster, 2003). Studies noted that the ability to facilitate discharge is dependent on early and appropriate referral to occupational therapy for services (Craig *et al.*; Hobbs *et al.*, 2010; Mearns *et al.*, 2008; Welch & Lowes, 2005). Ready access to equipment was positively linked to an ability to facilitate timely discharge from the ward (Sutton; Wressle *et al.*, 2006). Teams with timely referral to occupational therapy allowed quicker assessment of the client and was linked with an overall ability to reduce length of stay (Sutton). Occupational therapists identified that the referral for services often came late once the client was deemed medically stable (Griffin, 1993). This placed higher stress on the occupational therapist who perceived their services as an afterthought and that they would be seen as delaying discharge if they identified any areas of concerns (Craig *et al.*). Hobbs *et al.* described the development of a referral triaging process for health-care services to circumvent referral issues and ensure ongoing appropriateness based on actual client needs. Mearns *et al.* identified that by developing appropriate clinical guidelines for practice, service provision was equitable and the process from referral to discharge developed clearly.

Discussion

This review analysed the literature that examines the nature of occupational therapy practice in the acute

physical hospital setting. It appears that this clinical setting continues to challenge therapists in relation to how they can best articulate, educate and provide occupational therapy services.

Points of tension

The recent literature (1991–2014) covers periods of significant cost cutting and increased accountability in worldwide health-care provision (Freeman *et al.*, 2009). The issue of how best to provide occupational therapy services in reduced time frames continues to be debated with no clear answers. With the acute occupational therapy role changing to one of rapid assessment and discharge, how therapists adapt to these changes can greatly influence their job satisfaction and certainty in their own professional identity (Edwards & Dirette, 2010). A clear understanding of what is achievable assists in the articulation of a professional role in a setting. This in turn minimises the chances of identity confusion as therapists are able to provide a clearer description of their clinical scope of practice to the wider team (Craig *et al.*, 2004; Cusick *et al.*, 2004; Edwards & Dirette). The ongoing difficulty in articulating this role may therefore lead to inappropriate (or absent) referrals for important occupational therapy services.

A key finding of this review was that therapists are often time poor and unable to extend their services to provide the full intervention and assessment necessary for their clients within a tight time frame. An opportunity to complete occupational therapy intervention targeting areas of occupational performance outside self-care was not commonplace. Growing time pressures and competing caseload demands have placed increased pressure on therapists who report they end up 'just fighting fires a lot of the time' (Craig *et al.*, 2004; Cusick *et al.*, 2004; Griffin & McConnell, 2001). A reactive approach to practice rather than an ability to be proactive in service provision leads to therapists becoming disheartened with the nature of their role due to an inability to contribute more.

Recognition of the need for therapists to be more 'occupation focussed' in practice was explored in this review. Consistently, the literature identified that to embrace an identity that reconnects to the philosophical basis of occupational therapy requires support from within the system to facilitate change. Currently the role left to occupational therapists in the acute care model is one of 'linking in' with aspects of their care provision. The literature suggests that occupational therapists become known for a subset of their practice; most commonly equipment provision, home assessments and discharge coordinating (Sutton, 1998). When practice is not 'philosophically guided' it leads to therapists adopting roles in areas they feel most present and useful in. By positioning themselves with an aspect of service provision occupational therapists afford themselves a professional identity which they may not otherwise feel they

have in this setting (Fortune, 2000; Griffin & McConnell, 2001). Unfortunately, by only aligning with these restricted areas of practice, occupational therapists are viewed by the wider team for only a small proportion of what their total worth in this setting could be.

Implications for practice

With growing evidence on the challenging nature of acute settings, a proactive approach is needed to encourage and support occupational therapists in this area of practice. Difficulties with establishing and maintaining an occupational therapy identity in this setting requires a collaborative effort from educators, managers and individual therapists. Educators need to ensure that the nature of acute practice is covered in the curriculum so graduates are better prepared for when they commence practice on the wards. Skills such as how best to maintain a client-centred lens in the context of rapid discharges and how best to manage a fluctuating caseload are skills highly valued and necessary for acute practice and warrant inclusion.

For occupational therapy departments, supporting therapists to meet daily practice demands assists in building clinically competent staff. Regular clinical supervision encourages professional growth and improves staff retention as therapists feel supported in their role. For novice therapists, the opportunity to refine their clinical processes in this area is enhanced when provided with regular and meaningful supervision sessions (Cusick *et al.*, 2004). Despite this, it appears from the literature that clinical supervision consistently fails to be prioritised in favour of clinical duties (Cusick *et al.*; Griffin & McConnell, 2001). Client needs are frequently given precedence over therapist needs and supervision is often omitted when clinical demands are at their peak. This focus on the immediate needs of the client rather than the long-term needs of the therapist leads to a false economy in which therapists become disheartened by the often reductionist and prescriptive nature of their work. Provision of regular clinical supervision provides therapists the opportunity to actively engage in the reflective process and shape their practice within the frameworks of the profession. By facilitating sessions that allow therapists to develop greater meaning from their client interactions, the use of an occupational lens in this complex area of practice is further encouraged.

Little robust evidence was identified in this review on how regular clinical supervision was being actively facilitated for therapists working within the acute setting. The benefits of meaningful, active and regular supervision include increased clinical skills and confidence in their role. This review highlights that in acute practice, therapists do not have access to regular clinical supervision. Effective strategies and structures including supervision frameworks and a nurturing departmental culture around supervision need to exist to increase its

perceived worth among therapists. With adequate departmental support therapists are empowered to articulate their occupational identity on the wards on which they work and as such, the occupational needs of clients –and therapists– can be met. Future research conducted with acute therapists on the development of an occupation-based supervision programme may provide further insight into how their clinical and professional needs can be supported and enhanced in this setting.

Study limitations

This scoping study specifically sought to develop an understanding of the nature of occupational therapy practice in acute physical hospital settings. The specificity of this question necessitated the exclusion of many aspects of occupational therapy practice in the acute care setting. The opportunity to review and examine a broad range of publications allowed for the inclusion of all publication types that met the inclusion criteria. Scoping reviews do not provide the opportunity to critically appraise the quality of publications included in this review. Therefore, no conclusions about the methodology, study rigours or bias may be made.

While aspects of occupational therapy practice that were specific treatments (i.e. use of InterX) or management of a specific condition (i.e. stroke) were excluded from the scope of this review, discharge planning was included. It was identified that the process of discharge planning was the result of many interactions between the team, client and their family (Roberts & Robinson, 2014) and not solely the responsibility of the occupational therapist. While occupational therapists identify they have an important role to play in the organisation, and facilitate safe discharge, multiple factors external to the occupational therapist are also considered before discharge can occur. As such the process of discharge planning was included in this scoping review to fully capture how occupational therapists engage with the discharge process and the factors influencing their involvement.

It is possible that using different databases may have yielded an increased number of sources. The iterative nature of the data analysis and summarisation may also have been organised differently by different researchers.

Conclusion

This scoping review has synthesised and presented current knowledge on the nature of occupational therapy practice in the acute physical-care setting. The findings of this review have the potential to contribute to the professions future direction in this area of practice. The importance of acknowledging and responding to the different practice challenges of novices and experienced therapists have been highlighted. For current managers and experienced therapists, investing in the development of client-centred strategies for novice therapists to

use in this area of practice would increase their clinical and professional confidence. Difficulties in maintaining a philosophically congruent approach to daily acute practice, including an emphasis on facilitating occupation in the acute setting has confirmed previous research in this area. Proactive change is needed by the profession to facilitate and support therapists in maintaining an occupation focus in acute care. The discharge focussed nature of the acute care role can undermine the perceived value of the occupational therapist to this setting and result in a simplistic view of the therapist's role. The importance of engaging in regular and meaningful supervision was a key finding of this review and was highlighted as a key resource novice therapists seek in this practice area. Regular supervision supports and encourages novice therapists to meet requirements of service delivery while ensuring they experience ongoing satisfaction in their acute care role. Current research suggests this is not occurring in practice. Adequate structures need to exist in occupational therapy departments that promote the value of engaging in clinical supervision with a specific focus on maintaining an occupational identity in this setting.

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3. RESEARCH DESIGN

3.1 INTRODUCTION

To address the research objectives, this study was completed in two stages. The first stage aimed to scope the breadth of occupational therapy practice in acute hospital settings. This was achieved through the completion of a scoping review of all available evidence about the research question. The findings of the scoping review informed the second stage of the study. Qualitative inquiry using a grounded theory approach was selected, and in-depth interviews, with a case study component, were completed with occupational therapists practising in acute hospital settings in Perth, Western Australia.

3.2 SCOPING REVIEW

A scoping review is 'a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence and gaps on research related to a defined area or field' (Colquhoun et al., 2014). A scoping review was completed to explore the breadth of current literature available on occupational therapy practice in acute hospital settings. In contrast to systematic reviews, a scoping review does not require a well formed research question nor does it involve assessment of the quality of evidence (McKinstry, Brown, & Gustafsson, 2014). Rather a scoping review aims to provide an initial assessment of the likely size and breadth of available research evidence (Grant & Booth, 2009). In addition to research papers, scoping reviews allow the inclusion of 'grey' literature in the form of government reports, preliminary research findings, policy documents and theses (McKinstry, et al., 2014). This method of evidence synthesis is considered particularly useful when limited data is known on the research topic, as is the case with occupational therapy practice in acute hospital settings.

The scoping review was completed using the framework recommended by Arksey and O'Malley (2005). The framework consists of five discrete stages:

1. Identify the research question
2. Identify the relevant studies

3. Select the studies to be included/excluded
4. Chart the data
5. Collate, summarise and report the results

The literature identifies scoping reviews as a useful tool when an overview of the evidence is needed (Arksey & O'Malley, 2005; Colquhoun, et al., 2014; McKinstry, et al., 2014). By exploring the breadth of current evidence available, a decision can be made on whether further investigations into an area of interest are warranted (Arksey & O'Malley, 2005; McKinstry, et al., 2014). Conversely, a criticism of scoping reviews is that by their very nature they can include lower quality research (McKinstry, et al., 2014). However, by including evidence from all levels of the quality hierarchy, a scoping review paints a picture of the full landscape aligned with the topic of interest. This was considered beneficial for the research area under exploration due to the limited data known on the topic.

Further description of the rationale and details on the methodology for the scoping review can be found in Chapter two.

3.3 QUALITATIVE METHODOLOGY

Qualitative research is the interpretation and analysis of data in the form of words rather than of a numerical nature (Denzin & Lincoln, 2003; Schwandt, 2001). Qualitative methods are most useful when used to describe the nature of a phenomenon, rather than to investigate its aetiology. (Borell, Nygård, Asaba, Gustavsson, & Hemmingsson, 2012). As a form of inquiry it uses multiple methods that are both interactive and humanistic in nature in an attempt to understand and draw meaning of human action as it occurs within its natural setting (Creswell, 2009; Denzin & Lincoln, 2003; Schwandt, 2001). As an understanding of the phenomenon of acute hospital practice was sought from the occupational therapists who work in this area, qualitative research was identified as a useful approach for understanding the participant's perspectives.

Recent studies into acute hospital settings have highlighted the various roles and tasks available to and completed by occupational therapists in this practice environment (Craig, et al., 2004; Griffin & McConnell, 2001). In addition, language use and identity of acute care occupational therapists has been investigated within an Australian context (Wilding & Whiteford, 2008, 2009). However, very few studies have explored the nature of the acute hospital setting through the descriptive voice of the occupational therapists working in this setting. Similarly, limited empirical evidence exists that explores the practice processes used by occupational therapists within acute hospital settings, including the Western Australian context. To specifically address these gaps a qualitative approach using grounded theory was chosen to explore the research phenomenon of occupational therapy practice within acute care hospital settings in Perth, Western Australia.

3.3.1 THEORETICAL PERSPECTIVE- GROUNDED THEORY

First developed as a qualitative form of inquiry in the 1960s, grounded theory draws its origins from within sociological and philosophical traditions (B. A. Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory is an analytical inductive technique that seeks to generate theory from the examination of social situations and the complex interactions and processes which occur within it (B. A. Glaser & Strauss, 1967; Stanley & Cheek, 2003).

Grounded theory is informed by symbolic interactionism which assumes that individuals intuitively order and make sense of the world they exist in (Heath & Cowley, 2004; Stanley & Cheek, 2003). First developed by Mead (1962) and Blumer (1969) symbolic interactionism infers individuals are self-aware, self-reflective and able to influence their behaviour based on their interactions with others (Heath & Cowley, 2004). Subsequently, the grounded theory researcher seeks to understand the realities that exist for an individual or group of people, and will assume that people sharing a common circumstance will also share some common meanings related to that situation (Stanley & Cheek, 2003).

Through a specific data collection and analysis process, grounded theory allows the development of a 'theory' to emerge that relates to the individuals or group under observation (B. A. Glaser & Strauss, 1967; Stanley & Cheek, 2003; Strauss & Corbin, 1990). This is considered particularly useful when there is currently limited theory which helps to explain the behaviours demonstrated in that area (Stanley & Cheek, 2003). Grounded theory uses a variety of data collection methods such as in-depth interviews, field notes, memos, audio tapes and observation which are inductive in nature. That is, the theory that emerges from the data set is grounded in that data, not influenced by current knowledge and literature on the area of research under study. Glaser (1978) expanded by identifying that extensive linking to the literature before data collection has commenced has the potential to impact researcher sensitivity and influence possible theory development. Glaser's approach differs subtly from that advocated by Corbin and Strauss (1990) who suggested guidance from the research literature can occur to stimulate theoretical sensitivity and early theory hypothesis (Heath & Cowley, 2004; Strauss & Corbin, 1990). While previous literature on acute care was reviewed and summarised by the researcher in the form of a scoping review (Britton, Rosenwax, & McNamara, 2015), this was not focussed in nature to a Western Australian, or even an Australian context. As recommended by Glaser (1978) this study engaged the literature to provide a wide description of the general area and to alert the researcher to the scope of potential possibilities that may exist. As previously noted, virtually nothing is known about the processes used by occupational therapists in the acute hospital setting and whether or not these are similar to those used by occupational therapists in other settings.

A grounded theory approach was selected as the logical basis for exploring and interpreting the experiences of acute hospital practice through the descriptive voices of the occupational therapists who work in this area. In the context of this study, grounded theory allowed for an understanding of the participants' experiences, interactions, actions, attitudes and values in response to the questions and clinical case study.

3.3.2 SAMPLING AND RECRUITMENT METHODS

Purposive sampling is a tool used by qualitative researchers to choose units based on their relevance to the research question (Creswell, 2009; Schwandt, 2001). For this study purposive sampling was used to identify hospitals with acute adult general medical wards that offered occupational therapy services within a Health Service in metropolitan Perth, Western Australia. At the time of this study, Perth metropolitan health services were divided into North and South. Each service included a mix of both tertiary and general hospitals funded either publicly or privately. This study was conducted within the South service as it included two tertiary level hospitals and two general level hospitals all publicly funded. The North service comprised only one tertiary and one general level public hospital appropriate to this study with the remainder of northern hospitals being rehabilitative in nature or privately funded. The differences between tertiary and general level hospitals include the variations in clinical cases and severity managed within these health centres.

Theoretical sampling as a tool is used by qualitative researchers to determine where, or from whom, data is collected next in line with the theory emerging from the research categories (B. A. Glaser & Strauss, 1967; Stanley & Cheek, 2003). For this research study theoretical sampling was employed when approaching participants from the general level hospitals. As theory began to emerge from the data set from tertiary hospital participants, general hospital departments were approached to determine whether their participant experiences extended or challenged that theory (Seale, 1999). This approach ensured that the theory emerging from the research data were transferrable and reflective of both hospital types.

Recruitment of participants occurred through an email which was circulated to the four occupational therapy Heads of Departments (HODs). The email included a cover letter outlining the aims of the research study, the project's ethics approval and the primary researcher's contact details. Occupational therapy HODs were asked to circulate the email to their acute care occupational therapy staff to inform

them of the project. An offer was also presented for the researcher to attend each department and discuss the research proposal in person. One department asked the researcher to present to all acute care occupational therapists and three departments circulated the research information via the HODs. Participants contacted the researcher via email if they wished to express interest in participating in the study. Thirteen occupational therapists contacted the researcher and elected to participate in the project. A summary of participant demographic information is found in Appendix D.

3.3.3 INCLUSION AND EXCLUSION- OCCUPATIONAL THERAPISTS

Inclusion criteria stipulated that occupational therapists working on current acute care wards were included in the research study. At the time of the study within Western Australia it was recognised that the names of acute care wards varied between hospitals in line with individual hospital policies. As such it was recognised that acute wards did not offer rehabilitation and catered specifically for the acute management of illness/ injury with clients often, but not always, referred directly from the emergency department. Occupational therapists were excluded from the study if they worked primarily on long stay, care awaiting placement, paediatric medicine or mental health wards. It was recognised that staffing frequently requires occupational therapists to manage multiple caseloads and specialties, so discussion with university supervisors would occur if a participant wished to participate but lack of clarity regarding their predominate ward work was identified. During the course of this research study no participants were excluded based on the exclusion criteria.

3.3.4 INFORMED CONSENT

Each participant was provided with an information sheet outlining details of the study (Appendix E). Written consent was obtained from each participant prior to the commencement of interviews (Appendix F). Participants were advised that they

may withdraw from the study at any time and that they would be de-identified on research data using a numeric code.

3.3.5 DATA COLLECTION

3.3.5.1 IN-DEPTH INTERVIEWS

In-depth interviews are used throughout qualitative research as a form of data collection. In-depth interviews provide researchers the opportunity to gather information that is not directly accessible through other methods – attitudes, values and perceptions on the research topic (Partington, 2001). Through the use of words, an understanding of the participants' social realities can become apparent to the researcher during the in-depth interview (Minichiello, Aroni, Timewell, & Alexander, 1995). Strategies such as active listening, observing non-verbal cues and paraphrasing the participant's narrative to ensure understanding, are employed during the in-depth interview to capture the expanse of qualitative data being provided (Serry & Liamputtong, 2010). As an understanding of the field of acute care occupational therapy was sought for this study, interviews were chosen as the data collection method as they allow the participants thoughts, feelings and experiences on the research topic to be shared in their own voices.

3.3.5.2 INTERVIEW GUIDE

An interview guide was developed following consultation with peers, research supervisors, literature review and personal reflections on clinical experience in the research area. As the research topic was acute hospital practice from the occupational therapist's point of view, interviews that were semi-structured in nature were chosen as the logical data collection method for the research sample. Semi-structured interviews provide the interviewer (researcher) opportunity to probe for depth and clarity while allowing the interviewee opportunity to convey their thoughts, feelings and experience on the research topic (Hitchcock & Hughes, 1989; Sorrell & Redmond, 1995). Semi-structured interviews are guided by the interviewer, but balance exists in the interview process that provides for the

expansion of the interviewee's responses as necessary to ensure richness of data collection (Hitchcock & Hughes, 1989; Partington, 2001).

Data was collected from the participants using a semi-structured interview guide in order to elicit extended responses (Appendix G). The questions focused on the participants' daily work routine, description of their role, their perception of wider team members' view of their role, any identifiable operational, organisational or personal factors that affected their acute care work and what they saw as their unique contribution to this setting. Additionally participants were provided a clinical case study to review before discussing their treatment plans and discharge arrangements for a client given their current circumstances. Participants were asked to provide demographic information including length of time practicing as an occupational therapist, length of experience working within the acute care setting, level of education, location of educational training and any other clinical areas where they have previously worked (Appendix H). Each interview was between 60 and 90 minutes in duration, was recorded on a digital recording device and transcribed verbatim by the researcher.

3.3.5.3 DEVELOPING THE INTERVIEW GUIDE

Pilot interviews with three purposively selected occupational therapists were completed to identify any issues with the interview questions and refine the clinical case study, as discussed below. The three occupational therapists were identified from the researcher's primary workplace. They were selected by the researcher as they had varying lengths of clinical experience in acute practice and expressed a willingness to participate in the study. Amendments were made to the interview questions and case study based on feedback provided by the pilot participants. The three pilot interviews also provided the opportunity to refine the interview structure and flow.

3.3.5.4 CASE STUDY

A case study is a qualitative approach that facilitates exploration of a research phenomenon within its context (Baxter & Jack, 2008). Case studies are considered a

valuable tool for qualitative research within the health science fields due to their ability to develop theory, interventions and evaluate programs (Baxter & Jack, 2008; Yin, 2009). A case study was chosen as it allowed the interviewer (researcher) to further explore how acute care occupational therapists are practising and the processes they use in a given clinical situation. To fully develop understanding of how the participants were practising and the processes they employ, context for the specific work environment is needed as this is where the clinical and decision making skills are utilised (Baxter & Jack, 2008). A single, descriptive case study was chosen for use within the in-depth interview process as it helps describe a phenomenon within the real-life context in which it occurs (Yin, 2009). The case study can be found in Appendix I.

3.3.5.5 INTERVIEW PROCESS

Previous clinical experience and awareness of current funding changes regarding the practice area was drawn upon when preparing for each interview. A cycle of reflection (with both research supervisors and within a written journal) was engaged in before and after each interview to assist in the review and modification of interviewing style and approach. The interviewing style was reviewed from transcripts so any necessary changes could be made.

As the researcher was a current, practising occupational therapist within one of the workplaces, there was a need to manage this potential bias. At the time of the interviews the researcher was not supervising any of the respondents in their clinical duties, thus reducing the chance of tainting the respondents' responses to the interview questions. This decision had been discussed with the researcher's line managers at the commencement of the research project and as a result the researcher was rotated into a different clinical area. At the commencement of the interview the researcher attempted to clearly convey their role to the respondent as one of researcher in the area under study rather than as a peer. Efforts were made to ensure respondents felt appropriately secure and comfortable to provide responses that accurately reflected their thoughts and experiences. The development of empathy and rapport was therefore essential for the transfer of

intimate knowledge relating to acute care practice from the interviewee to the researcher (Partington, 2001). The researcher's personal experience working as an occupational therapist within the area under study was seen as positively assisting with initial rapport building by providing a common implicit understanding of the study area. While some participants were known to the researcher through the workplace, all participants were provided the same opportunity to engage in general conversation prior to the commencement of the interview. This allowed the researcher to build trust with the participants to allow them to "open up" during the interview process and provide a rich description of their experience. Strategies such as actively listening to responses, pausing during the interviews and framing responses to allow appropriate follow up questions and expansion of answers were used to draw out respondents who were reticent. Provision of prompting questions and examples were also used to expand discussion.

Acknowledgement was made of the time each participant was providing for the interview and the negotiations they may be making within their clinical caseloads to accommodate this. Flexibility in scheduling interviews around the participants' caseloads and workplace commitments ensured that unnecessary stress was minimised. Interviews were scheduled within the participants' workplaces so efforts were made to ensure the room had minimal distractions and that participants had adequate time to complete the interview.

3.3.6 DATA ANALYSIS

3.3.6.1 CODING

Congruent with a grounded theory approach, data were analysed using a constant comparative method (Denzin & Lincoln, 2003; B. A. Glaser & Strauss, 1967). Data analysis and data collection occurred simultaneously throughout the study. This process allowed data collection to be directed by any patterns emerging from the data set (Strauss & Corbin, 1990). Each interview was read multiple times and a line by line analysis occurred where 'in vivo' codes were assigned to describe what was happening (Stanley & Cheek, 2003; Strauss & Corbin, 1990).

A process of 'open' coding was completed where the research data was scrutinised and the developing categories and concepts are clustered together. These clusters of data were given tentative labels and as data analysis progressed, the categories were refined and redefined concurrently.

An essential aspect of the open coding process is that concurrent step of 'axial' coding. This is where the relationships between the categories and sub categories are compared and intensely analysed to develop key relationships both within and between the categories (B. A. Glaser & Strauss, 1967).

Selective coding was used to systematically identify the core category emerging from the data set (B. A. Glaser & Strauss, 1967). This core category provided the basis for the development of a research theory as it pertained to occupational therapy practice in acute hospital settings.

3.3.6.2 MEMOS

Memos were used throughout the grounded theory process to preserve emerging ideas and hypotheses (Stanley & Cheek, 2003). The memos informed discussion with University supervisors and assisted with the data analysis throughout the duration of the study.

3.3.6.3 THEORETICAL SATURATION AND SAMPLE SIZE

Predicting the point at which theoretical saturation of the data will occur is not usually possible when planning a grounded theory study (Strauss & Corbin, 1990). This is because theoretical saturation only occurs at the point no new codes or categories are emerging from the sample size (Strauss & Corbin, 1990). The intention of this study was to explore the nature of occupational therapy practice within acute adult physical hospital settings. No new categories were identified after the completion of the data analysis from the twelfth interview. The thirteenth interview was completed as confirmation of no new categories of meaning from interpreting the data.

3.3.7 RIGOUR

Rigour in grounded theory can be determined through the use of a number of approaches (Chiovitti & Piran, 2003). For this grounded theory study, rigour was determined by applying the framework developed by Beck (1993) who identified credibility, auditability and fittingness as the main criteria for evaluating quality in grounded theory research.

3.3.7.1 CREDIBILITY

Credibility refers to how realistic and vivid the description and theory of the phenomenon is (Beck, 1993). This approach means that what has emerged from the data analysis is so faithful to the experience noted by the layperson in that situation; they relate it immediately as their own (B. A. Glaser & Strauss, 1967; Lincoln, Guba, & Pilotta, 1985). In grounded theory, credibility is also evident when other practitioners and researchers can identify the experience when they encounter it based on their reading of it in a study (Cooney, 2011). Credibility is enhanced within a grounded theory study by a built-in mechanism: the result of concurrent data analysis and collection and 'checking' of emerging categories (Cooney, 2011; Strauss & Corbin, 1990). By constantly validating emerging categories against tentatively selected ones, the theory that emerges can be seen as properly representing the participants' experiences. Credibility was further enhanced in this study by ensuring the participants steered the direction of inquiry that was, at times, unanticipated by the researcher. As data collection and analysis progressed, interview questions were modified to reflect emerging themes. This also occurred with the use of the pilot interviews to shape the questions and case study. Interview transcripts were provided back to the participants for member checking to ensure their true meaning was represented. The use of 'in-vivo' codes further ensured the credibility of the study as the participants own words were used to develop categories and themes.

3.3.7.2 AUDITABILITY

Auditability refers to the comprehensive maintenance of records relating to all methodological decisions, including sources of data, sampling decisions and analytical procedures (Beck, 1993; Cooney, 2011). For grounded theory studies this includes the use of memos to record all decisions as they relate to methodological and analytical decisions (Cooney, 2011). This process occurred throughout the research study with the documentation of meetings with research supervisors and the use of a journal to detail personal views and values and assumptions regarding the research topic (Beck, 1993).

3.3.7.3 FITTINGNESS

Often termed 'transferability', fittingness is concerned with demonstrating that the findings have meaning to others in similar situations (Beck, 1993; Cooney, 2011). This approach requires that the study has been described in sufficient detail to ensure that the findings can 'fit' into contexts outside the one directly researched and that the audience can find meaning within the research findings when applied to their own situation (Beck, 1993). The onus of ensuring fit for the researcher is that the research design and methodology is described in such detail that readers can judge the similarities of the study setting/context. Steps were taken to describe the research process in detail and to describe the study context.

3.3.8 ETHICS

Ethics approval for this study was obtained on 13/05/2011 by the Human Research Ethics Committee (HREC) of Curtin University (Appendix J). Further approval was obtained from Royal Perth Hospital Ethic Committee 12/10/2011 (Appendix K). As ethics approval for general hospitals is managed by tertiary hospital centres within Perth, reciprocal ethics approval was sought concurrently at the outset of the research project to ensure future availability to occupational therapy staff at these centres. Under the South Metropolitan Health Service (SMHS) Human Research Ethics Committee (HREC) reciprocal agreement, ethics approval was obtained 14/08/2012 for Armadale, Rockingham and Fremantle Hospitals (Appendix L).

Undertaking this research study raised many questions for the researcher: how to respectfully complete the study within the researcher's primary workplace; how to remain objective during the interview process; and how to manage personal responses to the participants' experiences working within acute care. Regular debriefing with research supervisors occurred where difficulties relating to the interview process were addressed. Furthermore the audio taped interviews were repeatedly listened to and memos were reviewed consistently during the coding stage and then discussed during supervision sessions.

As Head of Department support was needed to gain ethics approval, consideration was given to the need to engage direct line managers in a period of discussion regarding the proposed research project and associated time requirements needed for both the researcher and potential participants. Reflection was also given to how and when interviews were scheduled to minimise the impact on the researcher's own clinical caseload. This included utilising flexible working arrangements, taking advantage of leave cover and scheduling interviews where practicable around non-peak clinical periods.

Research respondents were assured of their confidentiality throughout the research process through the use of pseudonyms and by having all their data de-identifiable both from a personal and workplace stand point. This was considered an important ethical consideration to the interview process due to possible stressful situations being discussed. Concerns may have arisen if respondents felt there could be ramifications from their managers based on their interview responses.

3.3.9 DATA STORAGE

All data obtained as part of this study was stored in accordance with section 2.6 'manage storage of research data and records' of the Australian Code for Research Conduct of Research (Australian National Health and Medical Research Council guidelines (Australian Government, 2007)). Consent forms collected during the study were kept in a locked filing cabinet in a locked facility at Curtin University for a period of five years.

Electronic data including interview transcripts were stored on the researcher's computer and this was protected with a password. These digital files will be destroyed seven years after the conclusion of the project.

3.4 LIMITATIONS

For this study, several limitations were acknowledged. While at the time of this study there were two health services within Perth, Western Australia, recruitment of participants for this study was exclusively through one health service only. Potentially by incorporating study participants from the tertiary and general hospitals within the second health service different experiences may have been voiced. There are also no private/ public hospital splits within the health service utilised while one exists within the second health service. This may have yielded different categories and therapist perspectives on acute practice.

Recruitment of participant occupational therapists was also completed via email information circulated by the Heads of Departments (HODs) to their acute care staff. While one hospital elected to have the researcher present and discuss the research in person, by relying solely on HOD support for recruitment the participation of the acute therapists may have influenced. The response rate for the study was 13 occupational therapists across four hospitals. It is therefore noted that potentially there were other acute practice therapists at these hospitals that were not captured in the study sample. A further limitation was the gender imbalance. All participants were female. Therefore comparisons to the experience of male occupational therapists in this work setting are not possible.

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4.PUBLICATION TWO

Britton, L., Rosenwax, L., & McNamara, B. (2016). Occupational therapy in Australian acute hospitals: A modified practice. *Australian Occupational Therapy Journal*. doi: 10.1111/1440-1630.12298

Research Article

Occupational therapy in Australian acute hospitals:
A modified practice

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Background/aim: Ongoing changes to health-care funding Australia wide continue to influence how occupational therapists practise in acute hospitals. This study describes the practice challenges experienced by Western Australian acute care occupational therapists. Then, it explores if and how acute care occupational therapists are modifying their practice in response to these practice changes.

Methodology: This study used a qualitative grounded theory approach. Semi-structured interviews were completed with 13 purposively selected acute care occupational therapists from four Western Australian metropolitan hospitals. Data were analysed using a constant comparative method to provide detailed descriptions of acute care occupational therapy practice and to generate theory.

Findings: Five conceptual categories were developed. The first two addressed practice challenges: pragmatic organisational influences on client care and establishing a professional identity within the multidisciplinary team. Three categories related to therapist responses are as follows: becoming the client advocate, being the facilitator and applying clinical reasoning. Finally, modified practice was identified as the core category which explains the process whereby acute care occupational therapists are ensuring they remain relevant and authentic in the acute care context.

Conclusion: Western Australian acute care occupational therapists are practising in a highly complex health context that presents many challenges. They are responding by using a modified form of practice that ensures

occupational therapy skills remain relevant within the narrow confines of this health setting.

KEY WORDS acute care, clinical reasoning, hospital, occupational therapy research, professional practice.

Introduction

Pressures on the Australian health-care system, such as Activity-Based Funding and increased demands, continue to influence the roles undertaken by health-care providers (Kirby, 2010). Interventions traditionally delivered by occupational therapists in acute health care have not been immune to these changes as they are challenged to meet the newest health-care requirements (Griffin, 1993; Griffin & McConnell, 2001).

A recent scoping review into the nature of acute hospital settings highlighted the growing difficulty of using occupation in daily practice (Britton, Rosenwax & McNamara, 2015). As the health landscape has moved towards a greater emphasis on financial accountability, the kinds of occupational therapy services that can be adequately provided in the time frames permitted have changed (Shiri, 2006). The challenge for occupational therapists in an acute setting is to provide a service congruent to the philosophy of the profession while demonstrating value to the payer.

The breadth of occupational therapy intervention in this setting has reduced, with discharge facilitation now identified as the aim for the majority of occupational therapy practice in acute care (Britton *et al.*, 2015). The discharge process is seen as incorporating home assessments, risk assessments and equipment provision (Britton *et al.*). Despite the positive contribution made through facilitating client discharge, the reductionist nature of acute practice raises some concerns for occupational therapists (Shiri, 2006). Wilding and Whiteford (2008) found that therapists in this setting had difficulty in articulating their role using occupational therapy principles. Limited opportunities to engage thoroughly with clients across a broad spectrum of meaningful occupations were linked with reduced job satisfaction

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and increased professional frustration (Shiri; Wilding & Whiteford, 2008). These concerns were more routinely raised by novice therapists who struggled with the limited support they received to develop their occupational therapy identity within an acute health context (Cusick, McIntosh & Santiago, 2004).

Despite these challenges, Australian hospitals are the second-largest employer of occupational therapists in the country (Australian Institute of Health and Welfare, 2013). Research has found many graduates aspire to begin their careers in acute settings where the possibility of experiencing varied clinical caseloads and having access to a large peer network exists (Britton *et al.*, 2015; Fortune, 2000). However, the prominent medical focus of acute hospitals and the growing need to demonstrate financial accountability causes practice issues for occupational therapists who work there (Griffin, 1993; Wilding, 2008; Wilding & Whiteford, 2008).

The challenges brought by such rapid change to the Australian health-care system are nonetheless accompanied by concurrent opportunities. Changes to the operation of public acute hospitals provide opportunities to adapt the occupational therapist role. Developing knowledge of how occupational therapy principles are applied within the narrow bounds of acute care will guide future teaching of therapists in this practice area. Detailed understanding of how occupational therapists use their professional knowledge to meet client needs is essential to ensure adequate support, and structures exist to foster the profession in this setting.

This article describes the practice challenges faced by Western Australian occupational therapists in the acute hospital setting as they strive to meet the fiscal accountability expected of them from the wider health system. Additionally, it aims to explore if and how occupational therapists are modifying their practice in response to these practice challenges.

Methodology

A descriptive qualitative approach (Creswell, 2009) was chosen to explore the research phenomenon of occupational therapy practice in acute care settings. Grounded theory was chosen for two reasons. First, grounded theory allows the detailed exploration of a research area from the voices, interactions and actions of the research participants (Glaser & Strauss, 1967). As empirical evidence on the nature of acute care occupational therapy practice is limited (Britton *et al.*, 2015), grounded theory elicits novel analytical explanation via the individuals who interact and engage with the phenomenon under study (Creswell; Denzin & Lincoln, 2003). Second, grounded theory provides the means to generate theories as they relate to the research phenomena. This is particularly important for the research described in this article as it has implications for

occupational therapy teaching and practice in the acute setting.

Sampling and participants

Purposive sampling (Creswell, 2009) was used to identify four hospitals with acute adult general medical wards which offer occupational therapy services within a Health Service in metropolitan Perth, Western Australia. An email, including a cover letter outlining the aims of the research study, the project's ethical approval and the primary researcher's contact details, was circulated to the four occupational therapy heads of department (HODs). Three HODs circulated the email to occupational therapists currently working on the acute wards. At the fourth department, the researcher presented to all acute practice occupational therapists. Occupational therapists working on long stay, care awaiting placement, paediatric medicine and mental health wards were purposively excluded as these areas of practice were outside the scope of this project.

Thirteen occupational therapists contacted the primary researcher and elected to participate in the project (Table A1). Demographic information on participants was collected over the duration of the data collection process to ensure varying lengths of clinical experience. While it was initially the intention to use theoretical sampling as identified by Glaser and Strauss (1967) to aid data collection, theoretical saturation of the data was reached precluding the need for further data collection via this method.

All participants were provided with an information sheet outlining the details of the study. Written consent was obtained prior to the commencement of interviews. Participants were de-identified using a numeric code, and data were stored in accordance with Australian National Health and Medical Research Council guidelines (Australian Government, 2007). Ethical approval was obtained from the Human Research Ethics Committees of Curtin University, Royal Perth Hospital Ethics Committee and South Metropolitan Health Service Human Research Ethics Committee.

Data collection

Data collection occurred primarily through semi-structured interviews completed by the participants at their place of work at a time selected by each participant. Interviews were between 60 and 90 minutes in length. Informal communications where field notes and memos were made were also used. Interview questions were open ended, and participants were asked about a typical work day and their role on the acute ward. Participants were also given a case study so as to discuss their standard treatment approach and to explore their clinical reasoning (Table A2).

Three pilot interviews were completed to inform and refine the interview questions. The case study was refined during the pilot phase to reflect a typical acute

adult general medical ward admission. The pilot participants were occupational therapists purposively selected to have varying lengths of work experience in acute care to ensure breadth of knowledge.

Data analyses

Congruent with a grounded theory approach, data analysis began at the time of data collection (Denzin & Lincoln, 2003). As the initial data directed future data collection, data were systematically analysed using a constant comparative method (Glaser & Strauss, 1967). This approach organises the many ideas that emerge from the data into a constructed theory about the phenomena under exploration (Denzin & Lincoln; Glaser & Strauss). A constant comparative method, which involved line-by-line analysis of each research interview and accompanying field notes, was completed where each unit of data was assigned a code through a process known as open coding (Corbin & Strauss, 2008). Each unit of coded data was then compared and analysed with all other coded data in that category through axial coding to develop key relationships within and between categories (Glaser & Strauss). This process continued until theoretical saturation of the data occurred (Corbin & Strauss). Selective coding was used to systematically identify the core category emerging from the dataset (Glaser & Strauss). This core category provided the basis for the development of a research theory as it pertained to occupational therapy practice in acute hospital settings. Memoing was used throughout the process to preserve emerging ideas and hypotheses (Stanley & Cheek, 2003). The memos informed discussion with the co-authors and assisted with the data analysis throughout the process.

Study rigour

To ensure trustworthiness of the data, each research interview was transcribed verbatim by the primary author and provided back to the research participants for member checking. Data analysis was completed to ensure the participant's words were present in the research findings, by repeatedly listening to the audio recordings, reading the transcriptions and assigning 'in vivo' codes (Corbin & Strauss, 2008). Triangulation was achieved with the use of purposeful sampling, multiple sources of data (interviews, memos and field notes) and collaboration between the primary researcher and the two co-authors. Detailed descriptions of research participants (demographic information, length of experience in acute care, total career experience and location of professional training), along with information on the research methods, interview setting and research findings, ensured transferability. Memo writing and audit trails were employed to allow cross-checking of work and ensure conformability and credibility of the data analysis (Willig, 2008).

Findings

All study participants were women. Their mean age was between 25 and 34 years. Their mean length of career experience as an occupational therapist was 56 months (4.6 years), and their mean length of experience on acute care wards was 15 months (1.25 years). Two thirds of the participants were WA trained. All thirteen occupational therapists worked within a multi-disciplinary team (MDT), which included, variably, a medical consultant lead, physiotherapist, social worker, speech pathologist and nurses.

Description of current acute occupational therapy practice

Descriptive analysis of the research data lead to the development of five conceptual categories.

Environmental practice challenges: Pragmatic organisational influences on client care

The first conceptual category relates to the external factors the participants described as negatively impacting on their ability to provide direct client care. In particular, difficulty in planning their daily work schedule, due to the referral-based nature of their service, was seen as a great inefficiency. Unlike other members of the MDT, the occupational therapists were not wholly based on any one hospital ward. They were often required to move between wards many times a day to see referred clients. The time required to accommodate various ward team meetings and different ward requirements hindered their ability to maximise direct care to clients.

Documentation necessary for clients to be discharged home frequently monopolised the participant's time. Difficulty in gaining access to client notes and completing referrals for services both within the hospital and outside, as well as the associated follow-up calls to ensure paper-based referrals were received, reduced time available for direct client care. For many participants, inconsistencies within service providers at both a hospital and community level meant an ongoing need to spend time identifying and learning the intrinsic workings of other agencies. For the participants, designated time to complete documentation was necessary in each daily work schedule.

Additionally, all participants spoke of the pressure to discharge clients from the hospital in the shortest amount of time. Due to these constraints, associated with fluctuating caseload numbers, participants explained that most contact with clients was restricted to assessment practices. Participants voiced a need for easy access to equipment for clients and space for activity of daily living assessments. Difficulty in accessing the required resources on the wards, due to lack of storage and inadequate treatment space, was recognised as influencing their ability to complete assessments and interventions efficiently.

If an elderly (client) wants to go home and be able to cook a meal, in a (sic) acute setting, because you are given such a big caseload you don't have enough time to go to the kitchen everyday with them. So you can do the assessment, but there is not a lot of time to take them to the kitchen all the time to make sure they can prepare the meal and find out the difficulties that they are having and just keep practising and teaching them the new techniques. (Participant 6)

Personal practice challenges: Establishing a professional identity within the multidisciplinary team

The participants acknowledged ongoing difficulty in building a professional identity in the acute setting: one that showcased the breadth of their practice for this setting. Reduced presence on the wards, as a result of being a referral-based service, negatively affected their ability to establish a prominent visual identity in their team. Being unable to have a base on a ward for the day meant that participants were not close at hand to answer impromptu questions or to engage in spontaneous team discussions.

The overarching need to ensure a client was on the ward for the least amount of time led the participants to focus on very similar, very specific aspects of intervention that could easily be achieved in a short time frame. An identity for the participants, borne out of familiarity, emerged as the participants found themselves aligned with intervention practices that were visible, easily understood by the wider team and supported a quick client discharge. While the majority of participants were accepting that the occupational therapy role in this setting was largely prescriptive in nature, a struggle to align this practice approach with their university training hindered their ability to clearly articulate an identity in this setting.

Sometimes, it appears that they think we are just there to give them (the client) a shower chair or frame and that's our job. (Participant 3)

The participants expressed difficulty with having an occupational therapy role that they found hard to define in the acute setting. Lack of clear definition regarding their work intentions affected how they were subsequently perceived by the MDT. Individually, the participants were all able to identify their unique contribution to the working environment and the wider team. They believed that they offered a more comprehensive, holistic approach to individual clients than their MDT counterparts. However, they expressed frustration as they believed the acute care MDT under-utilised their skills, seeing them solely as providers of equipment, safety monitors and responsible for home assessments to facilitate quick discharge.

Of particular concern, all participants identified a lack of understanding by the medical profession of occupational therapy practice. Limited interaction with medical staff and the frequent turnover of junior doctors were identified as possible causes. Inadequate time for education of the MDT regarding the full scope of occupational therapy practice was linked by participants to the receipt of a 'generic allied health referral' rather than a more specific, goal-oriented referral.

Response 1: Becoming the client advocate on their hospital journey

This response relates to the process whereby the participants demonstrated a willingness to be the 'voice' for clients as they moved through their hospital journey. This belief originated from their knowledge of the profession that they had developed from their university studies. The role of client advocate was seen as more than advocating in the moment of an acute illness presentation. Rather it involved developing a clear awareness of their clients' future needs and desires outside the hospital. Information was then actively disseminated to the wider team and other necessary agencies. Participants expressed the belief that they alone (as opposed to others in the MDT) offered the most complete view of their client's social, cultural and environmental situation. Identifying the subtleties of each client and how this might affect discharge were seen as strength of the occupational therapist in this setting.

The shortened time frame of the acute setting precluded the engagement of many clients in detailed allied health interventions. By frequently using the time available with clients to systematically collate all information relating to ward-based performance, the participants then advocated strongly for both their present needs (hospital based) and future (home based) requirements. Terms such as 'holism' and 'holistic view of the person' were used commonly as justification for their involvement in the advocacy process. Participants stated that their holistic approach was what set them apart from the wider team and made them the most appropriate team member to complete this role.

I feel like that the physios are more directed towards just mobility and social workers more social stuff and supports, whereas we look at not just their everyday activities we also look at how everything else combines – their mobility their social, as well as how they themselves are functioning. So in a way it's more holistic. (Participant 10)

While the participants valued the contribution from their colleagues in the MDT, they argued that each team member spoke of only discipline-specific issues and solutions. A perceived failure to take into account other necessary information that may impact on discharge, and future participation in desired occupations, led to

the participants strongly identifying the advocate role as an important feature of acute occupational therapy.

Response 2: Being the facilitator – Enabling team action

The participants took ownership over the need to formulate and action a discharge plan for their clients in the acute setting. With time constraints prohibiting the use of extensive interventions, the participants became the primary liaison between the client, their family and the wider team. Using their knowledge of hospital processes and available community supports, information was systematically categorised into potential problems to identify gaps in service needs. This often led to extensive discussion with the wider team regarding discharge issues and with clients' families regarding support requirements at home. The nature of this setting saw the participants adopt the facilitator role as it was viewed as complementary to their primary focus of facilitating discharge. By acting as the facilitator, the participants became involved in all aspects of the client's acute hospital journey.

The importance of discharge safety in the acute context meant that participants were frequently the team member making the decision for discharge to occur. Their suitability for assessing discharge safety was expressed as being intrinsically linked to their ability to assess risk and to evaluate the 'big picture'.

The development of the facilitator role in acute occupational therapy practice was viewed both favourably and unfavourably by the participants. In an area of practice strongly ruled by time pressures, some participants felt obliged to orchestrate safe discharges quickly, regardless of the client's needs. Being referred to as 'holding up discharge' or 'the person who will say if you can go home' resulted in participants often feeling undervalued for the work that they could offer. Conversely, other participants relished being known for their problem-solving abilities when orchestrating client discharge. It afforded them a presence on their respective wards that was viewed positively by the wider team.

It seems that every time they have a complex client that they don't know what to do with them and I go up there, in my role as the OT, we are so dynamic and we do consider so many different areas. And we have really good connections in terms of who we can refer on and all those sort of things; we can actually solve a lot of problems.

(Participant 8)

Response 3: Clinical reasoning

The participants valued their fundamental occupational therapy skills and tried at all times to apply them to this setting. However, to meet increased work demands, they demonstrated a condensed approach to their

clinical reasoning processes. The participants spoke of refining their ability to ask 'targeted' questions of the client. As opposed to less time pressured settings (e.g. rehabilitation), being able to quickly hone in on areas of concern was essential to the discharge process. Assessment commencing from the moment of first referral ensured that as much relevant information was collected in as short a time frame as possible.

When reviewing the case study, all participants demonstrated a uniform, systematic approach in their assessment of the client. From the basic information presented, the participants revealed an estimate for the clients' potential length of hospital stay by demonstrating a broad understanding of the more common impacts a disease may have on a particular client group. Drawing on their experience of how a specific condition would affect a client with similar demographic information allowed the participants to commence discharge planning before or shortly after their first client interaction. Each participant outlined a similar list of the further clinical information they would require for their assessment. This thinking framework allowed the participants to approach the first client interaction armed with a list of community services they would possibly engage to progress the discharge plan. Time constraints necessitated a need to go in to their assessments with a pre-established framework of possible challenges and strengths, as well as multiple follow-up options that would enable their discharge plan.

The limited time spent with each client necessitated a need to start building a picture of the clients' discharge situation quickly. A desire to include the client and family with decision making was not always practicable. A need to engage other service providers, make referrals within the team and make decisions in a rapid time frame often hampered this ability. Rapidly building rapport with the client at the first interaction was essential for enabling the discharge process to occur without necessarily having further direct input from the client, allowing the participants to commence MDT liaison and discharge planning by speaking on behalf of the client. The rapid speed at which the participants consistently reviewed the potential success or failure of each discharge option against new information, possible risks, safety issues and practicalities of the situation led participants to systematically refine the team's discharge plan quickly. By facilitating the discharge process, the participants were able to revise team expectations in response to variations in the client's condition.

Core concept: Modified practice

Analysis of the research data identified the five conceptual categories outlined above. Further theoretical formulation, as suggested by Strauss and Corbin (1990), helped uncover the relationships between the conceptual categories and revealed the core category of *modified practice* (Figure 1).

This concept reflects the instinctive changes participants were making to their daily practice in the acute care context. Without specific planning, the participants had evolved their work practices into something that was usable and complementary to their workload. They modified their practice. Modified practice occurred when the participants enmeshed their fundamental occupational therapy skills with the practical realities of the acute setting to provide a rapid, considered response to their clients' needs. The strategies used to modify their practice were developed within the system and constraints of the acute wards. These strategies became versions of traditional roles of occupational therapy with their own clinical reasoning, roles modified, yet specifically related, to the profession.

Discussion

This study explored acute care occupational therapy practice in Perth, Western Australia. Analysis of the study participants' narrative data enabled an understanding of the current workplace challenges and practice responses. For the participants in this study, an ability to modify practice from a more traditional occupational therapy approach ensured that fundamental occupational therapy skills continued to exist in this setting, albeit in a truncated form.

Research into acute occupational therapy practice has previously highlighted the importance of both early referrals for services and access to resources in order for occupational therapists to work quickly towards client discharge on acute wards (Britton *et al.*, 2015; Griffin, 1993; Griffin & McConnell, 2001). When timely referrals for occupational therapy services have been received, a noted reduction in length of stay for clients in this setting has been found (Sutton, 1998). Despite previous research demonstrating the importance of managing external influences on practice, our findings confirm that acute therapists still struggle to navigate these challenges to their practice within the acute context.

The discharge-focussed nature of the acute ward was further identified as negatively influencing the participants' ability to build a strong identity in this setting. Participants identified time constraints and the referral-based nature of their work as key factors in an inability to adequately showcase the depth and breadth of their skills in this setting. Lack of clarity regarding purpose and identity in acute care is not new for the occupational therapy profession (Griffin & McConnell, 2001; Wilding & Whiteford, 2008). The pressure to discharge clients in ever shortening time periods causes ongoing difficulties for occupational therapists who struggle to assert the value that they bring to acute care (Wilding, 2008). Inability to adequately implement an occupational focus in this setting led to the participants being unable to clearly articulate their work in this context.

Our findings suggest that acute care occupational therapists are intuitively modifying their practice in response to the social, economic and political landscape of the acute setting. Modifying practice occurred with three distinct changes: (i) becoming the client advocate on their hospital journey, (ii) being the facilitator of team action and (iii) applying rapid clinical reasoning.

The participants championed their clients' causes beyond the acute medical presentation. An acceptance of the limited time available to complete detailed occupational therapy intervention in acute care prompted the participants to expand their service away from hands on intervention and into a client advocacy role. As no additional resources were required, the participants could complete their advocacy role away from the physical ward location; this took into account the referral-based nature of their work. Participants spoke of this as falling neatly within the breadth of occupational therapy, as their advocacy work was completed using a holistic view of their client.

Within the acute setting, occupational therapy has largely been characterised as coordinating a safe and effective discharge (Britton *et al.*, 2015). The skill of assessing discharge risk ensures that occupational therapists are frequently included at this stage of the client journey (Atwal, McIntyre & Wiggett, 2012). For the study participants, their ability to facilitate a safe discharge for clients involved extensive liaison and planning at a ward level beyond simply the provision of a home assessment or piece of equipment. The participants demonstrated an expanded role in the dissemination of pertinent information throughout the wider team. By developing a forward-thinking framework for each client's situation, the participants coordinated team members towards solutions as potential discharge problems arose. This ensured that while discharge remained the wards primary outcome, the participants could shape how discharge occurred by systematically integrating the clients desires into those of the wider team.

Occupational therapy clinical reasoning was observed as being condensed and concise in the acute setting. In order to respond appropriately to the demands on their time, the study participants have developed a rapid integrated approach that allows them to function on the acute wards. The literature describes several types of clinical reasoning specific to occupational therapy. These include procedural, interactive, conditional, pragmatic and narrative reasoning (Mattingly & Fleming, 1994). The use of clinical reasoning can be viewed as the thinking framework through which therapists organise and support their clinical thinking (Neistadt, 1998; Schell & Cervero, 1993). The research findings suggest that out of necessity, the study participants were rapidly integrating their clinical reasoning to ensure that they have an appropriate framework appropriate to the acute care setting. This study builds on previous research by Crennan and MacRae (2010) who

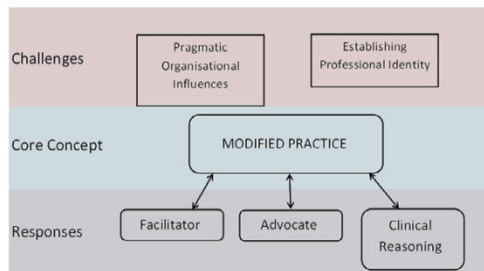


FIGURE 1: Conceptual categories.

identified differences between the clinical reasoning skills of novice vs. experienced therapists in acute care. We suggest that the clinical reasoning necessary for effective acute occupational therapy practice is rapid in nature and has developed as a response to exposure in this setting.

When considering the modified practice occurring within the acute care setting, the implications for occupational therapy education and clinical practice are significant. Instinctively, therapists in the acute setting are forging a role for themselves which differs fundamentally from what is 'university taught' occupational therapy (Wittman, 1990). By failing to recognise and fully articulate these changes to acute practice, occupational therapists undervalue the work they perform in this setting. Included in the education of occupational therapy, students should have clear guidelines on how to manage practice in the acute setting. Demonstrated by the changes made by the study participants, occupation is seen as the overall outcome of practice but can rarely be utilised as a treatment medium in this setting. Instead, acute therapists were drawing on their knowledge of occupational therapy models and frameworks to showcase the client-centred, holistic roles they could fill in this setting. In order to ensure new graduates feel confident to articulate their roles, acknowledgement is needed that facilitating community follow-up on may be sufficient in this setting. The alternative is that graduates who enter this workplace become disheartened by unachievable expectations. Further education on modifying clinical reasoning for acute care work would be advantageous.

From a clinical perspective, the importance of a critical reflection process warrants re-emphasising for both individual therapists and hospital occupational therapy departments. Therapists need support to embrace and articulate the professional artistry that has evolved in acute care settings. Without confidence to detail their current practice, therapists are at risk of minimising their value in client-centred roles. Given the challenges encountered in this setting, developing a concise framework for clinical decisions to relay to the wider team is

essential for the participants to demonstrate practical value to this setting.

Study strengths, limitations and future research

The nature of qualitative research means that the depth of the research question is both a strength and limitation of this study. By researching in depth the acute practice setting, new understanding has emerged of the acute practice context. However, the findings cannot be widely generalised to settings outside that which was researched in this project. Findings may, however, be applicable to other similar acute hospitals in Western Australia and indeed Australia due to the national changes currently occurring within the Australian health-care system. Additionally, the findings from this study may offer guidance to occupational therapists working within other areas of acute hospitals around Australia. Health-care changes are occurring at all levels of the Australian health-care system and similar practice issues, as identified in this research project, may be experienced in other settings. The use of 13 participants for this study was sufficient to allow theoretical saturation of the data to occur. Future research that specifically explores clinical reasoning in the acute setting would be advantageous. By identifying the strategies that best nurture the development of a rapid, integrated approach to clinical reasoning in acute care, a stronger identity for occupational therapists in this setting could be supported.

Conclusion

This study contributes a theoretical understanding of current acute care occupational therapy practice. Acute care occupational therapists are practising in a highly complex health context that presents them with many practice challenges. As an intervention-based occupational therapy approach is often deemed as incompatible with the acute setting, these therapists are expanding into roles where occupational therapy skills can be best utilised. Therapists have developed a truncated form of occupational therapy with modified clinical reasoning processes and have embraced a client advocacy and facilitator role in this setting. Education addressing the unique demands of the acute setting would empower future graduates to champion occupational therapy principles in this challenging health context.

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APPENDIX

TABLE A1: *Demographic information of occupational therapy respondents*

Participant	Total years of experience	Time on current case load	Caseload specialties	Locally trained	Age group
1	42 months	9 months	General medicine/renal/heart/lung transplant/cardi thoracic/urology/ear, nose, throat/diabetes/ophthalmology	Yes	18–24 years
2	66 months	8 months	Burns/general medicine/department of geriatric medicine	Yes	25–34 years
3	21 months	12 months	General medicine/oncology bone marrow transplant/haematology/immunology/gastroenterology	Yes	18–24 years
4	132 months	42 months	Acute assessment unit	Yes	25–34 years
5	66 months	6 months	General medicine/emergency department	No	25–34 years
6	20 months	3 months	General medicine/short stay unit/intensive care unit	Yes	18–24 years
7	120 months	60 months	General surgery	No	35–49 years
8	36 months	12 months	General medicine	Yes	25–34 years
9	12 months	8 months	General medicine	Yes	18–24 years
10	21 months	8 months	Acute medical ward	Yes	25–34 years
11	84 months	6 months	Annual leave for general medicine	No	35–49 years
12	48 months	10 months	Cardiology/cardi thoracic/oncology	Yes	25–34 years
13	60 months	12 months	Medical assessment unit	NO	25–34 years

TABLE A2: *Interview format and examples*

Interview questions	Study aim
Can you describe a typical day for me? What about a stressful day?	Explore practice challenges
What do you see your role as? Can you describe what you think your fellow team members view as your role? How does this impact your practice?	Explore practice challenges
Can you identify any factors within the hospital that influence your daily practice? Which are the most influential? How do you manage them?	Explore modified practice
Case study: Mr B is currently being admitted to your ward after being transferred from emergency. The doctors are with him but you meet his wife as you enter the room. She reports to you she found him in the backyard and that he was trying to get up from the ground using the back step. She called an ambulance as she was unable to assist him off the ground herself. Mrs B is unable to expand on exactly what happened as she was inside at the time. When you review his case with the doctors they report XRAYs and a CT head have reviewed no broken bones and no head injury. His admitting diagnosis is deconditioning, and it is noted that he does have some lower limb bruising.	Explore practice challenges
Case study questions	Study aim
Based on this information alone, can you describe your approach for this client on admission?	Explore any modified practice
Can any of your intervention be delegated to another team member? If yes, why? If no, why not?	Explore any modified practice

5. DISCUSSION

5.1 INTRODUCTION

Into the future, the provision of healthcare in Australia will be influenced by attempts to minimise costs and meet growing expectations from consumers. Greater access to information about health, higher expectations of their health care providers and an increased desire to be more involved in healthcare decisions means consumers will increasingly shape future health care provision. Exponential growth of technology, with greater access to this technology, along with enhanced digital health information will change how health education is shared between consumers, families, health practitioners and students. For occupational therapists, the ability to respond to fiscal pressures along with the growing consumer voice will greatly influence how the profession practices in the future.

Acute hospitals provide comprehensive care to clients, where medical acuity requires time-sensitive treatment (Hirshon et al., 2013). Currently, clients over 65 years of age occupy approximately one-half of acute hospital beds. Population predictions indicate that use of acute beds by this age group will increase as the population ages and the size of the population over 65 years grows (O'Connell, Ben-Tovim, McCaughan, Szwarcbord, & McGrath, 2008; Schofield & Earnest, 2006). Advances in the management of chronic conditions mean people will live longer and with a greater number of co-morbidities (Cunningham & Sammut, 2012). Consumers of health services will require a continuation of health management beyond an episodic acute hospital admission. Greater collaboration with primary health networks to facilitate the seamless transition of acutely unwell people quickly into, and from, acute hospitals will shape future occupational therapy in this practice setting.

This chapter summarises the major findings of the thesis by critically appraising the state of acute hospital occupational therapy practice in Perth, Western Australia, most of which is relevant to other major cities in Australia. Current knowledge about the scope of occupational therapy practice in acute hospitals has been confirmed by this study through the extensive scoping review documented in chapter two, and by the participants in this research, whose views are documented

in chapter four. The regularly used initial and self-care assessments described in the literature were reported by study participants; however, study participants also reported their role on the acute hospital ward as predominantly directed towards discharge facilitation due to the pressures of minimal time allocated to clients and limited resources. In response to these pressures, the tacit roles of client advocate and team facilitator had developed. As comprehensively discussed in chapter four, the rapid nature of the acute hospital setting has meant occupational therapists intuitively modify occupational therapy skills so they can be successfully translated into the contemporary acute hospital context.

The discussion presented in this chapter will further consider the research findings as they relate to occupational therapy within the evolving health care system arguing that a proactive re-formed approach to occupational therapy is needed in the acute hospital. Recommendations for how this approach can be shared through education and further research are discussed.

5.2 IS OCCUPATIONAL THERAPY IN ACUTE HOSPITALS RELEVANT?

It is clear occupational therapists working within acute hospitals experience many practice challenges that are different from those experienced within the rehabilitation or community settings. It is now well-known, and confirmed within this thesis, that the scope of occupational therapy practice in acute hospitals has been reduced and threatened by the changing health landscape. The introduction of Activity Based Funding (ABF) has greatly changed how acute hospitals are resourced (Council of Australian Governments, 2014). Policies such as the Four Hour Rule (WA Department of Health, 2011) aimed at streamlining client movement within acute hospitals has further challenged occupational therapy. These policies have been implemented by government in an attempt to rein in hospital bed days as a method of minimising overall health spending (Council of Australian Governments, 2014). In spite of increased financial accountability, further innovations within health will continue to be sought to meet increasing user

demand for acute hospitals. As noted throughout this thesis, shorter bed days have been found to be problematic to acute hospital occupational therapy. Reduced time with clients is prohibitive to investing in in-depth, traditional occupational therapy interventions. Subsequently, acute hospital occupational therapy is typically characterised by its ability to coordinate safe client discharges in a time sensitive manner.

Despite clear evidence of the effect the changing health landscape has had on the scope of occupational therapy in acute hospitals, to date no significant transformation journey has been documented which shows the profession is adequately preparing for future healthcare reforms. Repeatedly, attempts have been made to continue with traditional approaches to occupational therapy practice in acute hospitals (Griffin & McConnell, 2001; Li-Tsang, 2003). This can result in occupational therapists who become frustrated with the limitations placed on their service provision within this setting and disheartened at their inability to contribute more to their clients. The thesis demonstrates that occupational therapists strongly value their communication skills and ability to champion their clients' causes across the acute hospital journey. However, the current approach to acute hospital practice hinders the ability to promote the potential of these attributes. As traditional practice approaches become increasingly incompatible with the acute context, occupational therapists continue to struggle to promote their identity and enact their role.

Ambiguity regarding achievable roles and occupational therapy identity in acute hospitals has been documented in the literature since the early 1990s (Moore, et al., 2006; Wilding, 2008). This ambiguity hampers the articulation of a clear occupational therapy contribution in the acute setting and makes integration with the multidisciplinary team more difficult. Griffin & McConnell (2001) raised concerns that acute care occupational therapists were noted as lacking a clear direction in this setting. Wilding & Whiteford (2008) found that difficulty embracing and using occupational therapy language led to a disconnection between practice and the philosophical basis of the profession. Without a clear understanding of professional identity, clinical decisions are not made in line with the profession's

belief system. For the participants in this study, lack of a clear identity led to difficulty in defining what they saw as their unique contribution on the wards in which they worked. As identified by this thesis, decreased staffing, limited resources and reduced time have not yet persuaded the occupational therapy profession to critically analyse how to provide services effectively within the acute hospital. Therefore, the current identity that has been adopted by acute occupational therapists is predominantly discharge-focussed. As discussions regarding health and health management increase, this discharge identity fails to consider the real value occupational therapy could contribute to clients in acute care. Future healthcare analysis predicts increased consumer involvement in healthcare decision making (Charlesworth, et al., 2015). As the proportion of technology-savvy 'baby boomers' in hospital wards grows, their expectations of health services will similarly increase.

This thesis further addresses a significant gap in the profession's knowledge base. A disconnect to the fundamental beliefs of the profession has led to occupational therapists who are dissatisfied with the breadth of current practice within the acute context. As current acute occupational therapy practice is not consistent with a traditional approach, it is not clearly understood by either occupational therapists or the wider health team. Research that explores how occupational therapists practise under recent changes to the acute health system is necessary to help support future occupational therapists to demonstrate professional worth in the acute hospital context.

5.3 MAINTAINING THE ESSENCE OF OCCUPATIONAL THERAPY IN AN EVER- EVOLVING SETTING

A major finding of the thesis was that working in the current acute context has resulted in significant modifications to traditional occupational therapy practice. Interpretation of the study participants' responses identified that an overwhelming requirement to facilitate client discharges had expanded the participants practice

into complementary roles where they could continue to use their occupational therapy knowledge in a truncated form. Developments of the client advocate and team facilitator roles were borne out of the practice challenges experienced in the acute setting. These roles are discussed in more detail in chapter four, in the qualitative article entitled *Occupational therapy in Australian acute hospital: a modified practice*. For the study participants, lack of explicit awareness of these roles was evident. Developing into the advocate and facilitator on the ward occurred in response to restrictions placed on accessible resources and the time available to spend with each client. By being the advocate and facilitator, the participants had roles where they could draw on their fundamental occupational therapy skills to promote the importance of their client's needs and wants in team discharge decisions. In the time-pressured acute hospital, these roles demonstrated a better fit for the occupational therapists. By promoting a client-centred approach to discharge, the occupational therapists ensured that a fundamental objective of the profession could exist in this setting, albeit in a modified form.

Despite the positive contribution these roles added on the acute ward, the value to the discharge process was often hidden. Inability to clearly articulate their clinical actions to the multidisciplinary team was experienced by the participants. As service provision often involved organised interactions with others, the participants had difficulty explaining this contribution in a tangible sense. These findings are confirmed by Hanson (2009) who identified that many aspects of occupational therapy practice within the acute medical setting go largely unrecognised.

Described as hidden practice, Hanson found that occupational therapists within acute care frequently failed to acknowledge and articulate their work. By failing to make practice explicit in acute care, an understanding of the tacit knowledge that exists cannot be extrapolated for education and learning. The current modifications demonstrated by the acute occupational therapists in this study suggest that while intrinsically valuable for managing daily work on the acute wards, modified practice was as yet unrecognised as a valuable occupational therapy identity.

There is little published research that explores how tacit knowledge develops in acute hospital occupational therapy. Repeated exposure to the requirements of

acute healthcare had shaped knowledge of how to work in this setting (Eraut, 2000). Knowing where and how best to use their occupational therapy skills became the often unspoken and accepted nature of acute care practice. For the occupational therapists interviewed, the tacit knowledge developed in the acute hospital was supported by the development of a rapid, integrated approach to clinical reasoning as discussed in chapter four. To date, research into occupational therapy clinical reasoning acknowledges the existence of multiple types of reasoning including scientific, diagnostic, procedural, narrative, pragmatic, ethical, interactive and conditional reasoning (Boyt Schell, 2003; C. Mattingly & M. Fleming, 1994). As outlined in chapter one, understanding of how each type of reasoning exists and its contribution to the formation of clinical decisions in occupational therapy has begun to be extensively reviewed (Boyt Schell, 2003; L Robertson, 2012). However, it is proposed here that the participants in this study both used and rapidly integrated the multiple named types of reasoning (C. Mattingly & M. Fleming, 1994) in an effort to meet rapid discharge outcomes in the acute hospital setting. To make rapid decisions in a time pressured environment, the participants worked quickly to form assessment, intervention and discharge plans even before they met the client. As expanded on in chapter four, clients were approached in a uniform and systematic way; and questions were highly refined and targeted to ensure maximum information was generated in the shortest amount of time. A rapid, integrated approach to clinical reasoning was developed out of exposure to the acute hospital setting and the workplace demands experienced within it. Utilising clinical seniors for discharge problem solving had assisted to significantly refine the approach used with clients in acute care. For the participants, they remained unaware of the unique changes they had made to their clinical reasoning process in the acute care setting.

As discussed by Fitzgerald (2012), reasoning in practice is influenced by the wider socio-political environment in which the decision is made. For acute hospital occupational therapists, this idea holds true. Changes to the funding and management of acute hospital wards greatly influence the time occupational therapists can invest in each individual client. Increasing expectations from the

client, occupational therapy department, hospital and wider health system interact to modify clinical reasoning processes in the acute hospital setting. The consequence of having limited time to invest in each client necessitated a need to make fundamental practice changes.

Within this thesis, the identification of the advocate and facilitator roles currently being undertaken by Western Australian acute occupational therapists provide clear opportunities for the profession when considering a future direction in acute care. Future healthcare planning indicates that there will be a rise of middle-class consumerism within Australia (Frenk, et al., 2010). Consumers will be better informed and more involved in their own health care (Frenk, et al., 2010). Conversations regarding client discharge plans will no longer be centred solely on the health team and the client. Increased collaboration with clients, their families and extended health networks will work to increase consumer empowerment within the health process. Occupational therapists within acute hospitals are already demonstrating that through the completion of tacit roles such as the advocator and facilitator they can meet the requirements sought from a future health system.

Future healthcare management for the elderly or those with chronic conditions will happen over a continuation, rather than individual episodic care events. The rise of co-ownership of health records, such as eHealth, will require the seamless transfer of information between health providers and consumers (Charlesworth, et al., 2015). Health professions such as occupational therapy that encourage cooperation and engage in the ready transfer of client knowledge have the potential to be extremely valuable assets for the future health system. For occupational therapists, embracing and building on the already existent advocate and facilitator roles would ensure occupational therapists are involved in facilitating the 'bigger picture' for individual clients beyond the hospital walls. By forming links before, during and after periods of acute health presentation, occupational therapy has the potential to support clients transitioning into, and from the acute hospital with greater ease. However, for occupational therapy to survive in this setting, a systemic shift is needed away from the current repeated attempts at maintaining a restorative

approach to practice in acute care as it is unlikely to yield satisfactory outcomes for the profession.

5.4 RE-FORMED PRACTICE FOR A REFORMING SYSTEM

It is widely acknowledged that health provision in its current format is unsustainable (Day, 2015; Frenk, et al., 2010). Innovation in how health services are provided to future consumers will be necessary to meet increased demand (Day, 2015; Frenk, et al., 2010). An increasingly digitalised world will make accessing, disseminating and engaging with up-to-date health information quicker and easier (Norbye, 2016). For occupational therapy, re-formed practice that includes these imminent visions is necessary for the future compatibility of the profession in the acute hospital.

This thesis has indicated that currently occupational therapists within acute hospitals in Western Australia experience difficulty expressing an identity and role to the wider team. Restrictions on acute practice over the past 30 years have led occupational therapy to work mainly within discharge parameters. While the participants in this study acknowledged they contributed greatly to the discharge process, the identity afforded to them lacked a connectedness to the underlying philosophical base of the occupational therapy profession. Clinical decisions made without the guidance of the profession's beliefs and philosophy has been shown to negatively impact on feelings of self-worth and job satisfaction (Edwards & Dirette, 2010; Law & McColl, 1989).

Occupational therapy researchers have implored the profession to develop a clear identity in the acute setting (Craig, et al., 2004; Wilding, 2008; Wilding & Whiteford, 2008). However, previous understanding of how occupational therapists work within acute hospitals was limited. They have also failed to adequately consider how occupational therapy could, or should be practicing in light of ongoing trends within healthcare. This research clearly details the implicit roles completed by occupational therapists in acute hospitals. Integrating this information into the broader context of public healthcare reform allows the identification of future

directions for the development of professional identity. As governments look to new ways of providing services to an increasingly mobile and informed population, a clear understanding of current scope of practice provides the tools necessary for occupational therapists to articulate professional boundaries and professional worth in future acute hospital work.

The results of this study indicate that presently, occupational therapists commencing practice in Western Australian acute hospitals feel challenged when confronted with the realities of this workplace. Professional education has not kept pace with the changing face of healthcare in Australia. Curriculum is varied and fragmented between institutions and it would seem that limited explicit education on the requirements of working within the acute hospital exists (Occupational Therapy Council (Australia & New Zealand) LTD., 2012). This has resulted in ill-equipped graduates who are unable to work cohesively within the acute setting or know where to assert their full potential (M. Gray, et al., 2012; Sutton & Griffin, 2000). For occupational therapy educators, curricula must keep abreast of current innovations, technologies, fiscal pressures and other changes to health care and health knowledge. Advancements in technology will require graduates to analyse and decipher vast amounts of information as they relate to community services, funding and grant options for clients in specific clinical settings but also for wider diagnostic groups within the population. (Garrett, 2012; Norbye, 2016). Changes to the use of technology will challenge conventional ideas of how to provide information to clients during periods of acute admissions. The increased availability of smart phones and personal technologies will allow health professions such as occupational therapists to engage in mass communication with clients in the acute care setting (Garett, 2012). An ability to track the needs of clients as they move between the acute hospital and their home would ensure occupational therapists continue to engage with clients for their continuation of care. Megatrend predictions point to an upwardly mobile workforce that will be both locally responsive and globally connected (Charlesworth, et al., 2015; Day, 2015). Proactive university education would prepare graduates to be members of a global workforce,

where knowledge and skills are shared further than currently experienced and with a wider reach of consumers, families and health networks.

Current university education is centred on informative learning where skills and knowledge necessary to produce competent occupational therapists are taught (Occupational Therapy Council (Australia & New Zealand) LTD., 2012). However, in a changing health landscape occupational therapy needs leaders to promote its cause. A need for explicit transformational learning to occur within occupational therapy curriculum would ensure that graduates become enlightened agents of change that are better placed to 'read' the health system. Greater understanding of the socio-political factors affecting health care could better prepare graduates for practice in acute hospitals as well as other health care settings. By being able to critically analyse how the acute health system works, occupational therapists will be better able to contribute to shaping it without the constraints of outdated ideals and resources (Garrett, 2012). Graduates will also be more aware of why modifications to practice are needed in the acute health setting. Restrictions on the nature of what can be provided within the acute care context lead many participants to struggle with adapting 'what they know' to 'what they could do'. For occupational therapists, this results in practice being reactive rather than proactive. Difficulty identifying how they fit within the current acute health context lead them to minimise their role to that of what was expected of them, not what they felt they could achieve.

Acute hospital occupational therapists could be supported to engage with primary health practitioners and community agencies above and beyond what currently exists. By engaging in the community support networks of at-risk consumers, occupational therapists would be best placed to facilitate team action should a presentation occur as they have ready access to up-to-date information provided by community sources. This shift requires extensive collaboration with primary health practitioners and community agencies. However, by utilising their skills as advocates and facilitators, occupational therapists could significantly improve the length and overall discharge management of consumers from the acute hospital. By preparing for an increasingly digital world, occupational therapists could take

advantage of new systems for health information sharing. Continuously updating and amending community supports before, during and after the hospital journey could significantly change the admission and discharge process for acutely unwell clients.

To support clinicians to make such a dramatic re-formed approach to their practice, clinical supervision is essential. Consistently, research in occupational therapy has highlighted the importance that regular supervision can make to identity formation in acute care (Cusick, et al., 2004; Griffin & McConnell, 2001). Despite this, in practice supervision is rarely prioritised (Cusick, et al., 2004). Supervision that goes beyond purely pragmatic purposes is needed to support occupational therapy within acute hospitals. To build on developing compatible roles in an increasingly consumer-driven acute care sector, greater use of critical analysis and reflection is necessary. When support systems exist, occupational therapists could feel empowered to proceed with a modified approach to practice in this setting without guilt that traditional practice is being abandoned. This could lead to greater clarity regarding professional purpose in the acute hospital setting.

5.5 FURTHER RESEARCH AND EDUCATION

The thesis proposed that to remain relevant in the acute hospital, occupational therapists have intuitively modified their practice. Questions regarding how occupational therapists are supported in their modified acute practice are raised, particularly how occupational therapists can be successfully supported to engage in a reformed approach to acute occupational therapy practice. Research that explores the translation of implicit tacit knowledge into explicit learning in acute care could assist in promoting professional roles and identifying professional parameters in the evolving acute health system. Additionally, increased education on the socio-political changes occurring within healthcare and how occupational therapy knowledge is being successfully integrated would be advantageous.

5.6 CONCLUSION

This research has identified that occupational therapists within the acute hospital setting are making an unconscious modification to their practice in order to ensure occupational therapy skills continue to exist in this setting. The research has expanded on previous research into acute hospital roles and detailed the unspoken client-centred roles that occupational therapists are fulfilling in acute care. As confirmed by previous research, ongoing difficulty with developing a clear identity has been highlighted in acute care. The practice challenges experienced by occupational therapists in acute hospitals are unique and greatly influence the work that can be completed in this setting. Occupational therapy education programmes need to include learning on how to respond to the socio-political changes occurring within local and global acute healthcare. Understanding the clinical reasoning skills necessary to meet the requirements of acute practice occupational therapy is also imperative. The future success of occupational therapy in both the acute hospital and wider health system is dependent on the ability of the profession to re-form its practice approach. The development of the advocate and facilitator roles highlights how a client-centred focus is being maintained. Occupational therapists need to embrace technology so their role can be effective across the continuum of client care and in a manner that will positively assist the profession's future in Australian healthcare.

5.7 REFERENCES

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APPENDIX A EVIDENCE OF PEER REVIEW:

ARTICLE ONE

Australian Occupational Therapy Journal - Decision on Manuscript ID AOTJ-2014-157.R1

onbehalf of aot.eo+wiley.com@manuscriptcentral.com on behalf of aot.eo@wiley.com
Fri 17/07/2015 7:27 PM

To: Lauren Britton <lauren.geddes@postgrad.curtin.edu.au>

17-Jul-2015

Dear Dr Britton,

It is a pleasure to accept your manuscript entitled "Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review" in its current form for publication in the Australian Occupational Therapy Journal.

Your manuscript cannot be published until you have signed the appropriate licence agreement. Within the next few days you will receive an email from Wiley's Author Services system which will ask you to log in and will present you with the appropriate licence for completion.

Authors will see edited word files and proofs before publication as an Early View article on our Wiley Online Library website and in the next available issue of the Journal. You will then receive proofs for final checking. Proofs will be sent by e-mail as an Acrobat .pdf (portable document format) file. Acrobat Reader will be required in order to read this file and can be downloaded (free of charge) from the following Web site: http://www.adobe.com/products/acrobat/readstep2.html?target=now. This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Following final approval of proofs, your article will be published on Interscience Early View, http://onlinelibrary.wiley.com/journal/10.1111/2-281SSN%201440-1630/earlyview in final form. Once the article is allocated to an issue of the journal, it will be taken off the Early View site and moved to the regular online issue. The publication date of the article is the date as it appears on Early View. Late corrections cannot therefore be made as the online versions are complete articles, and the online and print editions must have identical content.

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Thank you for your fine contribution. On behalf of the Editors of the Australian Occupational Therapy Journal, we look forward to your continued contributions to the Journal.

Yours sincerely
Prof. Anne Cusick
Editor-in-Chief,
Australian Occupational Therapy Journal

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Fotini Toso
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Associate Editor Comments to Author:

Please ensure you insert DOI numbers for every reference where these are available.
Please action the following from reviewer 2:-
Minor points identified: clarify us of 'practice' or 'practise' for verb - p. 1 line 31 'staff who practise ...'; p. 2, lines 38, 46.
Page 11 - I think this could read: 'the discharge focussed nature ...' (not discharged)

Reviewer(s) Comments to Author:
Reviewer: 1

Comments to the Author
Well done on the adjustments you have made to this paper. Reads well - suitable for publication in this format.

Reviewer: 2

Comments to the Author
A well-considered revision of the paper. The context and aim of the work are presented well, and findings relevant to current practice.

APPENDIX B EVIDENCE OF PEER REVIEW:

ARTICLE TWO

Australian Occupational Therapy Journal - Decision on Manuscript ID AOTJ-2015-093.R1

onbehalf of +aot.eo+wiley.com@manuscriptcentral.com on behalf of aot.eo@wiley.com

Thu 31/03/2016 20:29

To: Lauren Britton <lauren.britton@curtin.edu.au>

31-Mar-2016

Dear Lauren

It is a pleasure to accept your manuscript entitled "Occupational therapy in Australian acute hospitals; a modified practice" in its current form for publication in the Australian Occupational Therapy Journal.

First Look NEW: Please note although the manuscript is accepted the files will now be checked to ensure that everything is ready for publication, and you may be contacted if final versions of files for publication are required.

Your manuscript cannot be published until you have signed the appropriate licence agreement. Within the next few days you will receive an email from Wiley's Author Services system which will ask you to log in and will present you with the appropriate licence for completion.

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Thank you for your fine contribution. On behalf of the Editors of the Australian Occupational Therapy Journal, we look forward to your continued contributions to the Journal.

Yours sincerely
Prof. Anne Cusick
Editor-in-Chief,
Australian Occupational Therapy Journal

Editorial Assistant
Meg A'Hearn
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APPENDIX D DEMOGRAPHIC INFORMATION

Participant	Total years of experience	Time on current case load	Caseload specialties	Locally trained	Age group
One	42 months	9 months	General medicine/ renal/ heart/lung transplant/ cardiothoracic/ urology/ ear, nose, throat/ diabetes/ ophthalmology	Yes	18-24 years
Two	66 months	8 months	Burns/ General medicine/ Department of Geriatric Medicine (DGM)	Yes	25-34 years
Three	21 months	12 months	General medicine/ oncology bone marrow transplant/ haematology/ immunology/ gastroenterology	Yes	18-24 years
Four	132 months	42 months	Acute assessment unit (AAU)	Yes	25-34 years
Five	66 months	6 months	General medicine/ emergency department	No	25-34 years
Six	20 months	3 months	General medicine/ short stay unit/ Intensive Care Unit (ICU)	Yes	18-24 years
Seven	120 months	60 months	General surgery	No	35-49 years
Eight	36 months	12 months	General medicine	Yes	25-34 years
Nine	12 months	8 months	General medicine	Yes	18-24 years
Ten	21 months	8 months	Acute medical ward	Yes	25-34 years
Eleven	84 months	6 months	Annual leave across general medicine	No	35-49 years
Twelve	48 months	10 months	Cardiology/ cardiothoracic/ oncology	Yes	25-34 years
Thirteen	60 months	12 months	Medical Assessment Unit (MAU)	NO	25-34 years

APPENDIX E INFORMATION SHEET



Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

My name is Lauren Geddes and I am a post graduate student in the School of Occupational Therapy and Social Work at Curtin University of Technology. I am currently undertaking a research project for my Master's degree looking at a contemporary view of occupational therapy practice in acute care settings in metropolitan Western Australia.

Occupational therapists work in large numbers in fast paced, dynamic acute settings. In this context they are faced with many challenges: an increased emphasis on accountability; the speedy and flexible movement of patients in the health care system; challenging financial and environmental limitations; and the increasing requirement to adapt practice from more traditional interventions to ones better suited to this setting.

This study will explore the depth and scope of current occupational therapy practice in Western Australia and the factors identified by occupational therapists as influencing their daily practice at both an organisational, operational and individual level. The project will explore the clinical reasoning of occupational therapists in this setting and how it is used within the current practice.

The results of this research will increase our understanding of the nature of occupational therapy in acute care settings and contribute to efforts aimed at improving and maintaining quality occupational therapy practice within Western Australia. Findings will have significance for practitioners, managers and educators in both acute settings and the university sector around managing future practice in this area. Whilst the results of this research will be used for publications and presentations, participant confidentiality will be maintained at all times.

Interviews will be carried out with a number of occupational therapists who will be asked for their views on current occupational therapy practice in acute care settings. The interview will be recorded and will take approximately 45-60 minutes of your time. Participation in this study is voluntary and you may withdraw at any time without penalty. All information provided will be treated in a confidential manner and no names will appear on the transcribed interview. Extracts of the interview may be used in the research report, but you will not be identified in any way. Recordings will be erased following transcription. No risks are anticipated with your participation in this study.

If you have any questions or concerns regarding this project, please do not hesitate to contact either Lauren Geddes via email: Lauren.geddes@student.curtin.edu.au or telephone: 9283 7326 or the Chief Investigator Professor Lorna Rosenwax on 9266 3604. Gail Nesci is contactable as the site contact on 9391 2312. Lauren Geddes is a postgraduate student at Curtin University and this study forms part of her Masters of Philosophy.

If you have any complaints or concerns about the way in which the study is being conducted, please contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929

APPENDIX F CONSENT FORM



Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University
School of Occupational Therapy and Social Work

I, _____ (print full name), hereby agree to participate in the project 'A contemporary view of occupational therapy practice in acute settings in metropolitan Western Australia'. I give my permission to be interviewed and for the interview to be recorded. I understand the nature and intent of the research and have been given the opportunity to ask questions. I understand where to direct and further questions I may have. I have received a copy of both the consent form and information sheet and understand that participation in this study is voluntary and that I may withdraw at any stage.

Signed participant (occupational therapist) _____

Signed (Researcher) _____

Date: _____

This study has been approved for ethics through the Curtin University Human Research Ethics Committee OTSW-04-2011 and reciprocal approval through South Metropolitan Health Service Human Research Ethics Committee

APPENDIX G INTERVIEW GUIDE



Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

- 1/ Can you describe a typical work day?
 - i) What about a typical, stressful day?
- 2/ Can you describe the role on the ward you work in?
- 3/ How do you think different team members view your role?
- 4/ What do you think you bring to the acute care setting as an occupational therapist?
 - i) How do you think this differs from other team members?
- 5/ Can you identify any organisational factors that influence your daily practice at a hospital level? (For example, ward allocation, patient allocation)
 - i) Can you prioritise the top 3 of these that impact your working practice the most?
- 6/ Can you identify any operational factors that influence your daily practice at a departmental level? (For example, requirements for service provision, paperwork)
 - i) Can you prioritise the top 3 of these that impact your working practice the most?
- 7/ Can you identify any individual factors that influence your daily practice? (For example, stress, organisational skills)
 - i) Can you prioritise the top 3 of these that impact your working practice the most?
- 8/ Consider the following case study

APPENDIX H DEMOGRAPHIC INFORMATION SHEET



Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

- 1/ Length of time employed at this hospital:
 2/ Length of time employed as an occupational therapist:
 3/ Length of time employed on present ward:
 4/ Years of experience
 New graduate_____ 2>4 years_____ 5>9 years_____ 10 +
 years_____
- 5/ Part time_____ Full time_____
- 6/ **Gender** Male Female
- 7/ **Age group**
 18>24 years_____ 25>34 years_____ 35years>49
 years_____
- 50 + years_____
- 8/ **Education**
 Curtin University of Technology Edith Cowan University
 Interstate institute_____ overseas institute_____
 Undergraduate Post graduate GEM
 Other
- 9/ **Work History**
 Acute settings
 Community
 Mental Health
 Rehabilitation
 Vocational Rehabilitation
 Other_____

APPENDIX I CASE STUDY



Government of Western Australia
Department of Health
South Metropolitan Health Service

CASE STUDY

Mr B is currently being admitted to your ward after being transferred from emergency. The doctors are currently with him but you run into the wife as you enter the room. She reports to you she found him in the backyard and that he was trying to get up from the ground using the back step. She states she called the ambulance as she was unable to assist him off the ground herself. Mrs B is unable to expand on exactly what happened as she was inside at the time. When you review his case with the doctor's later that morning they report a XRAY and CT scan has reviewed no broken bones and no head injury. He's admitting diagnosis is deconditioning and he does have some lower limb bruising.

Based on this information alone; can you describe your approach for this client on admission?

OPTIONAL QUESTIONS FOR FOLLOW UP

Follow up question: What other background information would you need from Mr B and his wife to form your intervention plan?

Follow up question: You learn from talking with his wife that Mr B fell whilst practicing his golf swing; does this change your intervention approach for him?

Follow up question: Mr B is normally quite active and completes many leisure interests; namely golf and swimming during the week. Does this change your thoughts around his admission?

Follow up question: What would your recommendations be for this gentleman?

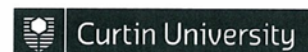
It is a busy day for you on the ward when Mr B has been admitted and you have lots of outstanding clients to see.

From the intervention you have listed is there anything that you feel you can delegate to other professionals to complete to decrease your workload?

Why do you feel these tasks can be delegated to other allied health when you previously felt it was your role to complete them?

From what you have said you can delegate can you describe to me what you feel is uniquely occupational therapy and that you must complete yourself?

APPENDIX J CURTIN UNIVERSITY ETHICS APPROVAL



Memorandum

To	Lauren Geddes
From	Teena Bowman
Subject	Protocol Approval OTSW-04-2011
Date	13 May 2011
Copy	Professor Beverley McNamara Professor Lorna Rosenwax

Office of Research and Development
Human Research Ethics Committee
Telephone 9266 2784
Facsimile 9266 3793
Email hrec@curtin.edu.au

Thank you for your "Form C Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled "**A CONTEMPORARY VIEW OF OCCUPATIONAL THERAPY PRACTICE IN ACUTE SETTINGS IN METROPOLITAN WESTERN AUSTRALIA**". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months **13 May 2011 to 13 May 2012**.

The approval number for your project is **OTSW-04-2011**. *Please quote this number in any future correspondence.* If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.

Teena Bowman
Research Centre Administrator
School of Occupational Therapy and Social Work
Telephone: 9266 4651
Email: t.bowman@curtin.edu.au

Please Note: The following standard statement must be included in the information sheet to participants:
This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number OTSW-04-2011). If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or hrec@curtin.edu.au

APPENDIX K ROYAL PERTH HOSPITAL ETHICS APPROVAL



Department of Health
Government of Western Australia
South Metropolitan Area Health Service

Royal Perth Hospital



ETHICS COMMITTEE

Frank M van Bockxmeer PhD MHGSA, FAHA, FFSc(RCPA)
Professor of Pathology and Laboratory Medicine
The University of Western Australia

Ethics Office
Room 5105 Level, 5 Colonial House
Tel: 9224 2292; Fax: 9224 3688

Ref: RA-11/029

(This number must be quoted on all correspondence)

12th October 2011

Ms Lauren Geddes
Occupational Therapy
Royal Perth Hospital

Dear Lauren

RA-11/029 A contemporary view of occupational therapy practice in acute hospital settings in metropolitan Western Australia

I am pleased to advise that the Royal Perth Hospital Ethics Committee has approved the above project under its reciprocal agreement with Curtin University Human Research Ethics Committee (HREC) (their Ref: **OTSE 04-2011**).

Under the reciprocal agreement, approval of protocol amendments and reporting of adverse events will be the responsibility of the parent committee providing approval, that is, the Curtin University HREC.

The RPH Committee is obliged by the provisions of the revised "National Statement" of the NH&MRC (2007) to monitor progress of all studies until completion. Therefore, this approval is granted on the understanding that you will *advise of any protocol amendments and submit an annual report to the Committee*.

The study has been assigned the RPH reference number **RA-11/029** and this should be quoted on all future correspondence regarding the trial.

Yours sincerely

Prof Frank van Bockxmeer
Chairman, Royal Perth Hospital Ethics Committee

The Royal Perth Hospital Ethics Committee is constituted and operates in accordance with NHC & MRC Guidelines.

Copies: Prof Lorna Rosenwax, Curtin University

APPENDIX L SOUTH METROPOLITAN AREA HEALTH SERVICE RECIPROCAL ETHICS APPROVAL



Government of Western Australia
Department of Health
South Metropolitan Area Health Service

Human Research Ethics Committee

15 August 2012

Ms Lauren Geddes
A/Senior Occupational Therapist
Neurosciences Unit
Shenton Park Campus
Royal Perth Hospital

Dear Lauren,

Re: A Contemporary View of Occupational Therapy Practice in Acute Hospital Settings in Metropolitan Western Australia

I am writing further to your email correspondence with Wendy Khoo, seeking approval from the South Metropolitan Health Service (SMHS) Human Research Ethics Committee (HREC), under the reciprocal agreement, to include staff in the Occupational Therapy Departments at Armadale, Fremantle and Rockingham Hospitals.

I have perused the documentation provided and I do not consider that the project raises any specific ethical or governance issues. I understand that staff in the OT Departments at these sites are supportive of the study and that it has been approved by the relevant Hospital Executives. I have, therefore, recommended to the Chief Executive that the study be approved at these site, on the basis that it has been reviewed and approved by the Royal Perth Hospital HREC.

I can confirm that the Chief Executive's delegate, on 14 August 2012 and under delegated authority from the Minister for Health, endorsed my recommendation to approve the study. Therefore, the study may proceed at Armadale, Fremantle and Rockingham Hospitals.

Under the reciprocal agreement, approval of protocol amendments and reporting of adverse events is the responsibility of the primary committee, in this instance the RPH HREC. However, the SMHS HREC requires annual progress reports and would like to be informed of any locally occurring events as they arise.

A reference number for this study will be forwarded to you by the HREC Office following the next SMAHS HREC meeting (2 October), which you will be required to quote on future correspondence with the Committee.

Yours sincerely

**DR DAVID BLYTHE
CHAIRMAN
SOUTH METROPOLITAN HEALTH SERVICE
HUMAN RESEARCH ETHICS COMMITTEE**

cc: Mark Woodman, RPH HREC (Ref No. RA-11/029)

Julie Bartley, OT, FHHS

Gail Nesci, OT, AHS

Catherine Fitzhardinge/Bev Wasylykewycz, OT, RPH

Human Research Ethics Committee
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